4958

Indian Health Service

MANAGED HEALTH CARE STRATEGIES WORKSHOP

Minneapolis, Minnesota
November 5-8, 1990

Sponsored by:
Office of Planning, Evaluation & Legislation
Division of Program Evaluation & Policy Analysis
Branch of Policy Analysis

Table of Contents

PREFACE

During the week of November 5-8, 1990, the Indian Health Service sponsored the Managed Health Care Strategies Workshop for tribal health programs and interested IHS staff. As part of the continuing effort to seek methods to improve health care delivery, this training workshop provided practical management tools to achieve cost savings while ensuring that health care procured from the private sector is appropriate in terms of cost and quality.

This workshop is the most recent meeting on this issue sponsored by the Office of Planning, Evaluation, and Legislation (OPEL) and has evolved out of a series of meetings which have continued to refine the manner in which managed care can be applied in the IHS and tribal programs.

The growing interest and enthusiastic response on the part of participating tribal programs and IHS staff are indicative of the need for more effective approaches to health care delivery in the light of increasingly constrained and finite IHS resources.

The IHS is grateful for the contribution and guidance received from the participants of this workshop and from the previous conferences which were held to define the IHS approach to this issue. Most especially, a debt is owed to the tribal and IHS programs that have been willing to test the managed care approach. This is a dynamic and continually evolving issue and will require even greater and wider participation if it is to remain a viable approach for providing health care to Indian people.

The IHS is appreciative of the willingness of TCI, Inc. to continue with the logistical support of this effort and for the development of this report. The IHS is fortunate to have had the interest and involvement of Sheila Leatherman, Vice President for Research and Development, United HealthCare Corp., from the earliest inception of this issue.

Managed Health Care Strategies Workshop: Introduction

Ramona Ornelas, R.N., M.P.H.
Chief, Policy Analysis Branch
Indian Health Service

Workshon Purpose.

This workshop was designed to assist tribes and IHS staff to maintain and/or increase managerial capacity to deliver cost effective, quality health care in a constrained economic environment.

Challenges posed by increasing health care cost inflation, a rapidly expanding Indian population, and the pressure of the Federal budget deficit to decrease Federal spending, are expected to increase. It is unlikely that the II-IS Budget will be increased to allow for new or expanded programs.

Roughly 50% of the MS Budget now supports purchase of health services from the private sector. Maintaining current levels of care becomes increasingly difficult. It behooves those responsible for providing health care to Indian people to entertain additional methods of providing or financing health care. If Indian health care is to be sustained then we must become smarter in expending scarce health care dollars.

Managed health care techniques of cost and quality control hold some promise for managing more effectively. It is no accident that managed care virtually dominates the health care market in the present and foreseeable future. These organizations have proved their viability in a very competitive market. The question is whether or not the management techniques they have can be applied to tribal programs and the MS. We believe they can with some adaptations. However, this requires a change in focus and behavior in which IHS and tribes move from simply being the payor for health care to being a player in the market place. Hopefully, the

information provided in this workshop will facilitate a reorientation to more effective approaches to health care.

Through a series of analytical studies and policy consultation meetings, the conclusion has been reached that managed health care delivery approaches hold substantial promise for tribes and the IHS to at least maintain the level of current services, or, preferably, to realize cost savings that will allow expansion of services. Consequently, this workshop was designed to provide an overview of managed care and the management tools used by managed care organizations to control costs and maintain quality of care. Broadly state, these tools are:

- Appropriateness of Care Utilization, Quality, and Cost Review
- Case Management
- Benefits Determination
- Information Management Systems
- Quality Assurance
- Referral Systems and Contracting
- Reimbursement Methods (Contracting, Negotiated Discounts, Capitation)
- Specialty Service Arrangements
- Applications: Tribal and IHS Case Studies

Faculty.

The managed care experts presenting at this workshop have a practical, working knowledge of the subject matter. Each is an acknowledged expert in his/her field with several years of experience in a highly competitive segment of the health care industry. The speakers have collectively and individually contributed to the tremendous growth of the managed care portion of the health care market. Each has made a sincere effort to learn as much about IHS and tribal programs as possible. The expertise of these

people will provide useful approaches to tribal programs and the IHS as they reorient their approach to health care.

Background and Evolution of Issue.

The issue of the alternative approaches to health care delivery and financing has evolved, over the last three years from an initiative to promote competition during the Reagan Administration to one of assessing alternative methods to improve the management of health care delivery. The IHS, from the time this issue surfaced, has defined its approach to alternative health care in terms of Indian Self-Determination and has proceeded with directions defined by the tribal consultation process.

The first national meeting, the Alternative Health Care Delivery and Financing Conference, on this issue was convened at Baltimore, Maryland in November of 1987. The intent of this meeting was to assess the potential impact of more interaction with the private sector as tribal corporate entities or as purchases of services from managed care organizations and to define a desirable direction for the MS.

The consensus of this first meeting was that there appeared to be a potential for enhancing Self-Determination. However, since the IHS had only limited experience in procuring health care from managed care organizations, it was the participants' recommendation that case studies of tribal and IHS applications be conducted.

Consequently, the IHS Policy Analysis Branch developed the Tribal Case Study Project in cooperation with the Office of the Assistant Secretary of Health. Four case studies of tribal programs and MS service units were developed to assess the potential for: (1) tribal incorporation as an HMO; (2) purchasing services from an HMO in lieu of a CHS program; (3) cost savings realized from purchasing drugs through an established Medicaid Formulary; and (4) establishing or procuring services from a rural HMO. The results of the Tribal Case Study Project are described in a report entitled "Assessment of Strategies to Promote Cost and Management Efficien-

cies in IHS Tribal and CHS Programs." The report is available upon request from OPEL.

The findings from the Tribal Case Study Project indicated that:

- Tribal incorporation as a federally qualified HMO is not generally feasible due to extensive financial and management requirements.
- Purchasing services from an HMO requires a guarantee of volume and membership for a defined period of time and resolution of the 3rd party reimbursement fluctuation problem. [1]
- Use of the Medicaid formularies decreases the cost of prescription drugs by at least 25% — a significant savings to the CHS budget.
- And, there are significant opportunities for joint ventures, shared services, and negotiated discount agreements with non-Indian community providers.

Underlying all the projects was the consistent lack of precise utilization and cost data necessary for a meaningful dialogue and negotiation between a tribe and a private provider organization.

As a result of the Tribal Case Study Project, it became apparent that more information and/or training was needed on the topic of managed care and the basic management techniques utilized by managed care organizations .

In order to provide the kind of information identified in the case studies and at the recommendation of the participants at the Baltimore meeting, a second national meeting, the Invitational Colloquium on Tribal Health Delivery: What Does the Future Hold?, was held in May of 1989, at La Jolla, California. The purpose of this meeting was to present a perspective on managed care and the relationship to tribal programs. In addition to health care industry expert presentations, alternative tribal

[1] The tribes studied were moving toward small 638 contracts, thereby decreasing their volume of clients.

health care delivery projects were presented as well. Featured were affiliation agreements, third party administration contracts, the ACCCHS study (capitation of -Medicaid), and a multi-tribal pooled insurance program for tribal employees.

The response to this meeting was very enthusiastic and the group was overwhelmingly 'in favor of IHS pursuing a managed care initiative and sponsoring another more focused training workshop on managed care techniques. In addition, they recommended that OPEL sponsor more studies to assess the potential for additional forms of alternative health care delivery and financing.

The IHS Policy Analysis Branch has sponsored additional studies under the auspices of the IHS Research and Evaluation Plan administered by OPEL. These studies assess the potential for risk sharing with private corporations (including insurance companies), adopting utilization reviews as a cost saving and quality assurance measure, Registered Nurse case management in a tribal CHS program, capitation of Medicaid, and alternative payment methodologies including prepayment.

The IHS has now moved beyond studying the viability of implementing various managed care strategies and has made a decision to implement managed care in the IHS. A Workgroup has been formed to develop an implementation plan.

Future Plans.

This present workshop was designed as a model and has been purposefully kept small in order to allow for questions and discussion pertaining to individual program needs. Since it is a model training workshop under consideration for replication in the future, feedback was invaluable.

Evaluation forms were distributed and each participant was encouraged to record responses and comments which will be coded and analyzed. Rec-

ommendations will be carefully evaluated and utilized in planning future workshops.

In addition to training workshops sponsored by the MS, there are other managed care workshops sponsored by various associations and other health policy nonprofit organizations. For those programs interested in developing a concept or preliminary plan for a managed care strategy, it is essential to conduct a thorough feasibility analysis. Only if it appears feasible should an implementation plan for a demonstration project be developed. The demonstration phase of development is important because it allows unforeseen problems to be resolved with minimal risk and gives a real indication of what works. Unfortunately, there is no federally sponsored demonstration grant program currently available to support these efforts. It may be worthwhile to seek support from philanthropic foundations now focusing on Indian populations.

Competitive non-recurring funding support for feasibility studies and demonstration model development is available through the annual IHS Research and Evaluation plan administered by OPEL. On an annual basis, solicitation for projects is sent out through the IHS Area Offices in late spring or early summer. Area Directors make the guidance and protocol for submissions available to each tribe and service unit. The proposed projects are reviewed, ranked and assembled into a plan for implementation in the next fiscal year.

In addition, the Tribal Management Grant Program administered by the Office of Tribal Activities, funds various kinds of management improvement projects on a competitive basis in accordance with prescribed priorities. Normally, feasibility studies or alternative demonstration model development are not a high priority.

Tribal Program Workshop Objectives.

The information provided in this workshop was designed to provide an overview of various components of managed care. By design, the work-

shop is an introductory course and, while it is comprehensive in scope, it was not intended to be an in-depth course. Each of the components presented could itself be the subject of an entire workshop.

Individual program needs should determine what information in the workshop is pertinent to each participant. As presentations are made, each participant should ask: "What are my next steps and what do I need from what source in order to meet my next objectives?"

Overview of Managed Care

Sheila Leatherman
VP, Research and Development
United HealthCare

Health Maintenance Organizations (HMOs).

HMOs are just one type of managed care. They are defined by the following criteria:

1. They must have a distinct, enrolled population eligible for services.
2. They must have a defined set of health care benefits.
3. They must have a predetermined, prepaid price.
4. Their services must be provided from a defined delivery system.

History of HMOs.

As early as the 1920s, a few progressive companies desired to create health care entitlement for their employees. They established systems for anticipating costs and set up relationships with physicians and hospitals in order to ensure employee coverage. Since then, HMOs have prohferated. Currently, enrollment in the nation's various HMOs is estimated at 45 to 50 million.

There are two basic models of HMOs of particular interest to the IHS:

1. Staff HMOs which employ all their own health care providers and function as a clinic, generally owning their own buildings.
2. Independent Practice Associations (IPAs) which contract with physicians who maintain individual private practices in the com-

munity. Generally, the physician's contract with the IPA represents only a small part of his or her practice.

HMOs have undergone a gradual transition during recent years. Originally designed to provide health care to a specific population (company employees), HMOs have gradually shifted to providing medical insurance coverage and services to varying populations including Medicaid and Medicare beneficiaries.

Problems and Issues Relating to HMOs.

1. Many HMOs have grown too fast and are attempting to satisfy needs of too many populations. By seeking contracts with Medicare, Medicaid and individuals, many HMOs have spread themselves thin. Many have insufficient experience to meet the resultant increased demands.
2. HMOs are undercapitalized. Many have geographically expanded their operations, incurring tremendous development costs. Further, many have deliberately priced their coverage lower than that of their competitors in order to expand enrollment, thus creating severe financial difficulties.
3. HMOs often face difficulties establishing and maintaining relationships with the community and physicians. For example, many physicians in hospitals feel threatened by the amount of control HMOs have over their financial situations.
4. HMOs have been criticized for focusing on costs at the expense of providing quality health care.

The Future of HMOs.

HMOs as individual organizations may come and go, but the basic concepts on which they are built (provider reimbursement, quality manage-

ment, utilization management, and risk management) will continue to be viable alternatives to traditional health care delivery.

Planning Managed Care Systems.

In planning managed health care systems, exact policies and procedures must be defined for: (1) utilization management, and (2) provider contracting.

In defining policies and procedures, focus should be placed on cost-effectiveness rather than cost containment — that is, attention must be on determining where to spend money in order to improve the health status of individuals. Priority should be given to quality.

Managed Care Concepts + Definitions.

1. Utilization Management — Directly related to quality assurance, utilization management is a technique which focuses on monitoring the use and overuse of services through three primary monitoring and intervention systems: authorization (precertification or prenotification); concurrent review; and case management.
   a. Authorization may be conducted through:
      1) Precertification, whereby a physician must call the managed care organization for permission to perform a specific procedure. (Permission is granted — or rejected — according to set guidelines. Precertification is particularly effective in controlling costs.)
      2) Or, prenotification, whereby the hospital or physician must notify the managed care organization that a procedure will be performed. (While prenotification does not save as much money as other forms of authorization, it encourages physician accountability. Further, it serves as a basis for

collecting the data needed to determine where money goes and which systems need better management.)

b. Concurrent review systems monitor and influence the health care service being provided. Inpatient services are investigated in terms of length of stay, resources used and patient discharge planning.

   The review method generally involves simple monitoring of patient services through telephone calls. Some plans utilize their own in-hospital nurses to conduct the reviews.

   Occasionally, concurrent review is used on outpatient cases where review may be conducted by personal or telephone interviews.

c. Case management systems are those in which the provider or HMO staff monitors the care of individuals or even whole populations. For example, case management monitoring concerns itself with reasonable protocols for treating all patients with a specific illness or condition, such as diabetes.

   The goal of utilization management monitoring is not simply financial. It also involves the objective that patients not be subjected to unnecessary procedures.

   By the same token, utilization management also aims to assure that services are not underutilized and that patients have access to preventive care in order to help reduce sickness or death. Providing regular mammograms after the age of 50 is an example.

2. cost — The challenge of monitoring health care delivery involves achieving a careful balance of concerns. On the one hand, emphasis should be placed less on cost than on quality. On the other, enough attention should be paid to costs that judicious use of resources is assured.

   According to the New ***England Journal of Medicine,*** 20-30 percent of medical care in this country is unnecessary. A primary example is Cesarean sections, up from 1 out of every 18 births in 1970 to 1 out of every ***4 in*** 1990.

3. Benefits Coverage Policy/Necessary Care — This is both a legal and an ethical concept. Through careful benefits design, managed care providers must define what kinds of coverage or service access patients should have according to the obligations and promises of their particular system. Preventive health care, catastrophic benefits, and transplants are examples of the types of care which must be considered.

4. Technology Assessment — This is the effort to determine the effectiveness and/or appropriateness of specific medical or surgical interventions, particularly controversial ones such as back surgery or liver transplants. Technology assessment seeks to translate what is technically or scientifically known into actual policy in order to determine what is worth paying for.

5. Quality — There are several first-stage ways in which quality of care can be judged. They include questioning a treatment's:

   a. Adherence to predetermined standards. For example, predetermined standards require that tubes would not be inserted in a child's ear unless a certain number of ear infections have occurred and trials on antibiotics have been unsuccessful.

   b. Adherence to the norm. This quality judgement is used when there are no practice guidelines or protocols. For example, if the Caesarean section rate in a community is about 20%, and 50% of any one physician's patients undergo sections, the quality of care received by these patients would logically be questioned.

   c. Maximum utilization of what is available. There may be situations in which enough money is not available to cover all the care needed, so the provider must optimize resources.

   d. Degree of success in increasing the probability of desired patient outcomes and reducing the probability of undesired outcomes.

   e. Adherence to accepted guidelines such as those developed, or being developed, by the Joint Commission on Accreditation of

Hospitals, the American Medical Association (AMA), or individual medical societies.

There are also-a number of second-stage methods for evaluating quality of care. These involve examining existing problems and attempting to correct them. They include questioning:

a. Clinical outcomes (Was there mobility after hip surgery? Blindness out of diabetes?) or tracking patient mortality rates.

b. Patient satisfaction. This can be done by examining the patient's relationship with hospital and physician.

c. Credentialing. The managed care organization must establish systems for determining provider background, capability and licensing. (The law holds that HMOs which choose to send patients out for services may be held legally liable for adverse outcomes.)

6. Risk Management — This enables health care providers to balance quality and cost issues. Risk management may be accomplished by:

a. Lessening financial risk through arrangements like capitation (paying the physician one amount to care for the patient regardless of treatment provided) or shared risk arrangements.

b. Lessening clinical risks through monitoring:

1) Costly or complex individual cases, such as those involving premature infants.

2) Problem trends in areas in which there seems to be inadequate access to care.

3) Underuse and overuse of physician appointments.

Quality Control through Credentialing and Performance Review

Gloria Swanson
Director of Medical Services
MedCenters Health Plan
Minneapolis, MN

The information offered in this presentation is drawn in large part from MedCenters, a nonprofit HMO in Minnesota which was organized by practicing physicians. Employers pay MedCenters to provide care to employees and dependents. MedCenters is responsible for delivering health prevention, health promotion, ambulatory, and acute care services. A management company administers nonclinical programs.

Cost effectiveness is a chief concern. Administrative costs associated with managed health care are high. (MedCenters' administrative expenses, including case management and review, run from 1 1-16% of budget.)

Because MedCenters, like any managed care contractor, is held legally liable for the quality of the care it provides, quality control is a chief concern.

Credentialing.

MedCenters ensures the quality of its services through an expansive provider credentialing program.

Credentialing involves the careful review and verification of each individual provider's professional background.

Each MedCenters provider is sent an application; in the state of Minnesota, HMOs have a joint agreement with the local medical society to verify the provider's claimed credentials.

Additionally, MedCenters has established the following minimum acceptance criteria:

a. Graduation from an accepted school of medicine;
b. Valid current state licenses;
c. Valid current DEA registration;
d. Admitting privileges at one or more local hospitals;
e. Current professional liability insurance coverage;
f. No history or involvement in any malpractice arbitration or settlement (although exceptions may be made in the case of some nuisance malpractice suits);
g. No history of denial or cancellation of professional liability insurance;
h. No health problems, as determined by the physician's own statements, which would interfere with his/her ability to practice medicine;
i. No history of professional disciplinary action.[1]
j. No history of chemical abuse.

[1]State boards of medical examiners, the National Board of Medical Examiners, and the Board of the Healing Arts, for example, may provide information about physicians who've been disciplined or sanctioned. In addition, the Federal Government has recently initiated a National Practitioner Data Bank to process information on disciplinary actions and malpractice cases nationwide. Because it is still in the early stages of collecting information, the Bank is limited in the amount of physician histories it can currently provide. It will, however, be a good future source of physician practice behaviors.

k. No history of termination of employment, criminal conviction or indictment.

l. No history of wasteful use of medical resources or failure to comply with any plan's utilization and quality assurance programs.

m. Absence of intentional falsification of the application.

Performance Review.

MedCenters has a written plan as part of its quality assurance program. If a provider is reported for substandard performance, the report is reviewed by a committee of the provider's peers in a manner that protects the rights of both the physician and the HMO. In the typical case, the committee may recommend disciplinary action or oversight of the provider for a specified period of time.

Monitoring Quality and Use of Services

Ellen Pinkowski, R.N., PHN
Manager, Concurrent Review
MedCenters Health Plan

This presentation reviews utilization management monitoring strategies which can be employed to monitor the use, and assure the quality, of managed health care services. These methods include: Precertification; Admission Notification; Referral Management; Concurrent Case Review; and Second Surgical Opinion?[2]

[2]Case Management, another utilization management strategy, will be discussed in the following workshop presentation.. See pages 23-27.

Like the preceding presentation, this one is based on the experience of MedCenters, a nonprofit HMO in Minnesota. MedCenters has a membership of nearly 250,000. It contracts with approximately 1200 physicians in 126 clinics and admits to 31 regional hospitals.

The described strategies are used (or have been tested) by the 30 staff of MedCenters' Department of Medical Services, which is divided into four sections:

a. Hospital Administration Review and Data Analysis Section, where hospital admissions departments phone for verification of patient eligibility and approval of services to be provided.
b. Concurrent Review Section, which administers reviews of acute care, discharge planning, and continuing care.
c. Quality Assurance Section, which monitors issues identified by case reviews, complaints, appeals, and credentialing.
d. Medical Policy Section, which clarifies coverage policies for services and evaluates the appropriateness of new technologies.

Case managers on MedCenters' Department of Medical Services staff must meet the following qualifications:

1. Bachelor's degree RN;
2. 3-5 years acute hospital (med/surg background), or HHC experience helpful;
3. Strong initiative, good sense of humor;
4. Excellent verbal and written communication skills;
5. Assertive personality to be able to work in emotionally charged situations;
6. Knowledge of community resources.

Each staff member receives training to prepare him/her. This includes education concerning the organization's mission, policies, and provider networks. A manual summarizing this information has been developed. New case managers make rounds with existing case managers.

Utilization Management Strategies.

Precertification

Precertification is the process by which a managed care organization is given advance notice of any elective admissions or surgical procedures. This gives the managed care organization the opportunity to verify coverage and to determine whether the service is appropriate.

Precertification is generally the responsibility of the patient, though contracts may be structured to require physicians to precertify admissions or procedures. In these cases, penalty systems should be built into the physician's contracts.

The precertification process generally includes:

a. Verification of member eligibility;
b. Evaluation of medical appropriateness of diagnosis, admission, care and procedure;
c. Assignment of length of stays and provision of procedures for obtaining extensions of initial authorization.

The following will facilitate a precertification procedure.

1. A clearly identified central phone number should be provided.

---

3 There are a number of ways to determine length of stay. Intensity of services guidelines can be used and are available from various sources.

2. The member or physician must be aware of his responsibility to obtain precertification.
3. Guidelines must be available to assist in making consistent decisions.
4. A medical director should be internally available if questions arise.
5. A list of surgical procedures, appropriate for outpatient surgery should be available.
6. In cases where outpatient surgery/treatment is standard, staff — if requesting inpatient admission — need to clarify if medical complications exist or if patient is poor anesthesia risk.
7. Staff should clearly communicate who is responsible for providing updates if an extension is necessary.

Admission Notification

This is a process by which the managed care organization is notified of nonelective — or emergency — admissions. Notification may be the responsibility of the hospital or the individual provider, depending upon predetermined policy.

MedCenters has worked out an admission notification system agreement whereby:

1. Providers call a central recorder with basic information, member ID, diagnosis, admission date, and attending physician for all MedCenters' admissions.
2. That information is passed on to utilization review technician, who verifies coverage, eligibility and appropriateness of admission.
3. If the technician can approve the admission, he/she notifies the hospital of the patient's coverage.

4. If the patient has not been admitted by a contracted provider, then MedCenters must arrange with the member's primary physician for an appropriate referral.
5. When the technician cannot approve a nonelective admission, the case is turned over to a case manager, who works with the attending physician and the primary physician to evaluate the patient for continued stay, transfer to another facility, or discharge.

The earlier an admission notification is received, the better. Early notification allows the managed care organization to get the appropriate parties involved early so that internal resources can be utilized and financial liability can be protected.

Referral Management

Through referral management, referrals to specialists outside the managed health care organization are arranged where internal services do not meet the patient's needs.

In making referrals, it is important that the managed care facility have the ability to limit the number of visits, procedures, and other services provided to members. Referrals should be specific in terms of services to be provided. (Is it to be a one-time consult or full diagnostic workup, one visit or three?)

The primary care physician is responsible for determining whether a patient should be referred to an outside specialist. Guidelines for patient referrals should be developed by a committee of physicians. Trends and patterns in patient referral should be tracked.

The following are helpful in facilitating referral management.

1. A mechanism to communicate authorization for care being provided outside of the HMO system is helpful.
2. The primary care MD determines if he/she can provide the needed care or if the patient needs to be referred to another provider.
3. When the Primary MD makes a referral, he should state if a one-time evaluation or a specific number of visits is authorized.
4. A paper system should be provided to doctors for referring patients. It should include a form that notifies the referral physician of the number of approved visits, a form that explains how to get an extension, a form that clearly states what is authorized. The forms should be multi-part to provide copies. The referral form should include as much data as possible, including patient name, provider name, diagnosis codes, number of visits allowed, etc. This will enable the managed care organization to track helpful data over time. A copy of the form should be given to the patient so the patient is aware of the specific limitations of the referral.
5. A committee of MDs should be established to review — where necessary — referral authorization for appropriateness and make recommendations for available alternatives.
6. Policies should be developed for primary MD to follow in making referrals.
7. System should be easy to use and understand.
8. A mechanism should be made available for members to file appeal of denied referrals.

Concurrent Case Review

Concurrent case review is the process by which the managed care organization can get medical information about its hospitalized members during their hospitalization. This can be performed either on-site or by phone.

MedCenters review staff look for appropriateness of admission, patient progress, length of stay, and discharge procedures in order to ensure quality of care and appropriateness of utilization. They also review cases for quality of care indicators (whether the admission was due to inappropriate outpatient management or whether the patient suffered from hospital-induced situations 'such as a fall or an error in medication, for example.) In conducting on-site concurrent case review, staff members have clear roles and responsibilities, taking care not to duplicate any hospital services. They are respectful of hospital policies regarding external review and patient confidentiality. Phone review is conducted only during specific hours of the day.

On-site review allows for direct access to physician orders, treatment plans, laboratory results and nursing staff... and thus greater accuracy. Anticipating on-site review staff, physicians tend to be more careful about case documentation.

For concurrent case on-site review to be cost-effective, hospital or ambulatory facilities should be geographically close, and there should be more than one or two patients to review at a time. If this is not the case, phone review may be the better option. Phone reviews may not be as accurate, so care must be taken to request specific information and to comply with the requirements of the facility.

There are a number of criteria sets available to assist the managed care organization in reviewing admission and continued stay. MedCenters uses the Appropriateness Evaluation Protocol (AEP), which looks at three categories:

a. Medical services being provided to patient, including surgical procedures and testing that can only be performed in the hospital setting.
b. Nursing life support services being provided (IV therapy, frequent nursing assessment or dressing changes).

c. Individual patient condition factors, such as the sudden inability to void or the sudden onset of acute confusion.

The InterQual Intensity of Service Severity of Illness Criteria. (IS/SI Criteria) is also available to the managed care community. These criteria break down into 'adult and pediatric sets, evaluating the various body systems (circulatory, respiratory, etc.). They break down further to review temperature, blood pressure, or laboratory values. Discharge screens are available on these criteria to determine if a patient is appropriate for discharge.

Literature on both the AEP and the IS/SI Criteria show that they are comparable. Both should be reviewed in order to determine which best suits the individual needs of the organization. They may be obtained by contacting the following:

AEP

Joseph Restuccia
Health Care Research Unit
Boston University Medical Center, Suite 1102 Boston, MA 02118
(617) 638-8188

IS/SI Criteria

InterQual, Inc.
44 Lafayette Road
P.O. Box 988
North Hampton, MA 03862-0988

Second Surgical Opinion

Another utilization management strategy is that of the second surgical opinion, whereby a second physician is consulted. If the findings of the original and the consulting physicians conflict, a third is called in and a de-

cision is reached through the agreement of two. Second opinions are often requested for surgical-procedures such as mastectomy, cesarean section, and back surgery. Depending on specific contracts and situations, second opinion physicians can be from within or outside the managed health care system.

MedCenters has not found the second surgical opinion strategy to be cost-effective, because physicians generally concur in their diagnoses.

Savings Strategies.

MedCenters has found that the use of continuing care resources (home health care, skilled nursing facilities, etc.) may be beneficial and may provide viable alternatives to extended hospitalizations. Such resources are particularly suited for patients involved with kidney dialysis, ongoing intravenous or physical therapy, post-stroke therapy, or treatment for low back pain.

MedCenters uses Medicare criteria to determine whether continuing care should be covered. Regional Medicare intermediaries can assist you for further information on continuing care.

Another area of savings is use of day-of-surgery admission. Many surgical cases don't require inpatient stay prior to surgery and physical workups, laboratory testing and paperwork can be done in the physician's office. On arriving at the hospital, patients are admitted and then sent directly to surgery. They are actually admitted to their hospital room from the recovery room.

Data Needs.

Regardless of the monitoring technique to be used, complete, accurate data must be gathered. Every managed health care program must develop

its own appropriate data system. The system should meet national data requirements but must also meet local needs.

MedCenters evaluates its cases according to discharges per month breaking them down by type of service — i.e., medical, surgical, obstetric, newborn, mental 'health. The number of hospital days utilized and the average cost per day for each admission is determined. Potential financial liability for hospitalized cases is calculated.

MedCenters recommends keeping track of the following data elements, whether using paper or computer systems:

a. Members;
b. Admitting and specialty physicians;
c. Admitting diagnoses;
d. Surgical procedures;
e. Type of admission (medical, surgical, ob);
f. Dates of admission and discharge;
g. Length of stay;
h. Other available insurance, such as motor vehicle, workman's comp, or product liability.

Computer packages have been designed to assist managed care facilities in gathering and tracking patient data.

Quality Assurance through Case Management

Jill Klingner, R.N., PHN
Medical Services Coordinator
MedCenters Health Plan

Case management is a utilization management strategy which involves monitoring the health care of entire population with emphasis. on:

1. Providing quality, medically-necessary care and ensuring that all eligible members receive appropriate services through appropriate systems. (The services an organization is able to deliver may not represent all the population needs; the organization must determine the maximum services its resources can provide and must explore community resources to meet the needs it cannot.)
2. And, containing costs.

Case management monitors the use of both outpatient and inpatient services and facilities. In high risk populations, many patients will cross over between the two, and the managed care organization needs a good system of communication in order to manage cases between the two services.

Outpatient Case Management.

The following types of patients/cases usually require monitoring through outpatient case management:

a. Outpatients with diagnoses related to high cost or high utilization, such as asthma, pulmonary disease, cancer, or AIDS.

b. Patients with a history of noncompliance leading to decreased health and high utilization of services for conditions such as diabetes, hypertension, or alcoholism.

c. Patients with comprehension problems, such as the elderly, children, or the developmentally disabled.

d. Patients with limited capacities for self-care, such as poor mobility or cognitive impairment, or families who cannot provide adequate care.

e. Cases with unusual providers and unusual requests such as Magnetic Resonance Imaging, CT scans, or outpatient surgery.

Initially, the managed care organization may not have the resources to target all cases. It should focus on crisis or post-crisis cases initially and, as it refines its systems, it will be able to deal with less serious cases.

The goals of outpatient case management include:

1. To facilitate access to a complete continuum of services from homecare to outpatient to hospital services and including health education and other services not necessarily provided by the managed care organization but available within the community.
2. To facilitate the choice of the most appropriate service level, whether hospitalization or a home health nurse.
3. To ensure a coordinated delivery of services to prevent duplication by other agencies in the community.

Outpatient management is the tool by which you can identify any segments of the population at risk for poor care, poor access to services, or late diagnosis. It also takes into account social and emotional environments which can restrict members' access to care. Once the at-risk populations have been identified and their needs assessed, appropriate referrals can be made and further health deterioration can hopefully be prevented.

The process of outpatient assessment includes the following activities:

1. Establish the member's eligibility;
2. Establish the member's individual needs with special attention to social support systems, environment/living situation, intellectual abilities, emotional stability/stressors, ability to perform selfcare, health history, and current physical condition and medical needs;
3. Establish a care plan according to your system's limitations and resources;
4. Assign the responsibility for the coordination of that care plan to one person who assumes responsibility for coordinating all services;
5. Implement plan of care;
6. Maintain ongoing reassessment and evaluation of outpatient needs so that services can be increased or decreased appropriately.

Inpatient Case Management.

Special attention and assessment must be provided for cases in which the inpatient:

a. Is hospitalized more than 5 days;
b. Has a special diagnosis;
c. Has an unusual length of stay;
d. Incurs high costs; or
e. Requires unusual providers/requests.

The managed care organization must determine the specific diagnoses for which it will provide care. IHS has defined five main categories of care. (See II-IS Medical Priorities in APPENDIX A.)

Each managed care organization must develop policies regarding the minimum level of care' it can provide for all of its members, year-round. Depending on its resources, an organization may be able to provide only emergency treatment (Category A of IHS Medical Priorities). The organization with greater resources may, in addition, provide its members acute and chronic primary and secondary care (Category C of IHS Priorities). And, so on.

The Process of Inpatient Case Management includes the following steps:

1. Establish whether patient is an eligible member admitted to the appropriate facility.
2. Access information on the patient from hospital or ambulatory facility charts, staff, nurses, therapists, or physicians, by phone or in person. (See Medical Record Documentation Outline, APPENDIX B.)

The following information should be documented:

1. Overall presentation of patient at admission (See QA/UM Screening Abstract in APPENDIX C.). Does the patient meet admission criteria for acute hospitalization? Why is he/she here? Why didn't outpatient management work?
2. Why was this problem not solved in previous admission?
3. What is the physical condition? Be specific. Document facts; use direct quotes.
4. What is the treatment plan? Find in MD's admission notes or orders.
5. Is there other insurance including Medicare, Medicaid, Workman's Compensation, Motor Vehicles, or other group plans, which may provide primary payment for inpatient services? (The hospital social worker can verify other coverage and help maintain those certifications.)

6. Are there legal issues pertinent to the case? (These might include clarification of-the organization's financial risk, clarification of its liability — especially in cases of denial of coverage — and notification steps when services are denied.)
7. Are there ethical issues, such as living wills, discharges against medical advice, child or adult protection issues, appropriate pain control, or euthanasia.?
8. Are there quality issues or trends in care which are not consistent with mission of IHS?

Once this information has been documented, it should be used to:

1. Assess appropriate hospital utilization using AEP, IS/SI (see page 20) or other criteria.
2. Assess appropriate medical management. This is especially important when contract physicians are non-MS providers. It is often difficult to get involved in the planning of care by outside physicians. Because outside physicians and managed care organizations may not agree on how the patient should be managed, the case review staff person must assume responsibility for patient advocacy.
3. Ensure that appropriate services, inside or outside, are called in. To assure earliest discharge, assist in arranging timely consults and alert discharge planners and social workers to the patient's expected needs so necessary services can be in place.
4. Investigate the cost-effectiveness of covering services that aren't normally covered (such as intravenous home therapy) in lieu of hospitalization.
5. Assess education deficits and/or needs of members and providers. Talk to families of members. Clarify misunderstandings about care limitations, as well as any other options for care.

Developing Medical Policy concerning Benefits

Kris Carlton, Director
Medical Policy, AETNA Health Plans

This presentation addresses the development of medical policy for determining benefits based on procedures used by AETNA Health Plans. The speaker, as AETNA's Director of Medical Policy, provides strategic direction to clinicians by overseeing three areas of policy development:

1. New technology assessment;
2. Assessment of established medical services, such as repeat cesarean-sections;
3. Assessment of billing appropriateness including coding accuracy.

Policy Development Process.

The process used for AETNA's Medical Policy development is as follows:

1. Identify specific issues according to populations involved.
2. Develop policy — describing what benefits will be available to the population.
3. Define benefit categories both categorically and specifically. Under the benefit category "Prescription Drugs," for example, list: drugs for which reimbursement will be provided, the quantity or length of supply to be covered, the dollar amount to be allowed per initial prescription and refill, co-payments, and any exceptions such as growth hormones, fertility drugs, etc.
4. Provide members with a written contract in order to assure reasonable expectations and avoid any misconceptions.

5. Define services to be provided for particular diagnoses. Where multiple alternative therapies exist, for maximum cost efficiency, steer population towards the most cost effective suitable service.

Issue Identification

AETNA identifies issues through a variety of channels. These include:

1. Monitoring activity and phone calls from managed health care organizations.
2. Monitoring the press and reviewing medical/scientific literature, including the ***Journal of the American Medical Society*** and the New ***England Journal of Medicine.*** (Once a new technology reaches the market, members will expect access to it.)
3. Developing relationships with manufacturers in order to (a) receive information before it is published and (b) to steer development of new technologies toward services which you believe most cost-effective and beneficial.
4. Analyzing data.
5. Tracking research. Criteria sets and other information regarding advances in research are generally available.

Supporting Policy

Once a medical policy is developed, certain techniques can be utilized to demonstrate its credibility.

1. Contact the American Medical Association or individual specialty societies for their written positions on products and procedures.

2. Contact the Food and Drug Administration or other pertinent government regulatory agencies for their decisions regarding particular devices and technologies.
3. Expert clinicians should also be consulted to support your policy position.

Status Policy

Written policy statements should be prepared. These statements should define services and describe their specific uses. They should clearly state intent of coverage or noncoverage and identify limitations or contra-indications to applying service. The statements should also identify any regulatory mandates or any other unusual circumstances which could impact the policy .

The typical AETNA Statement of Medical Policy on a given procedure or service defines the procedure, any related issues, and coverage limitations. It also enumerates criteria the patient must meet in order to qualify for coverage.

Reviewing Policy

A process should be developed by which policy drafts are reviewed. AETNA backs up its drafts with supporting bibliographies, research summaries, and expert opinions. The drafts and their accompanying backup are routed to assigned individual physicians who may request additional information or approve a draft for wider distribution. The draft is then forwarded to a committee representing administrative personnel and multiple medical specialties.

Distributing Policy

Policy statements should be distributed to all medical management personnel. The policy language should also be used to develop member contracts and member materials.

Policy Analysis

A system should be developed by which policies are analyzed once they are implemented in order to assess and report their effectiveness. AETNA currently compiles analysis information from claims data and from its multiple medical management processes. Through this system, costs and frequency of services are evaluated in aggregate as are policy positions as applied to individual cases.

Use of Information Systems in Managed Health Care

David Aquilina
Independent Consultant
4817 Vincent Avenue South
Minneapolis, MN 55410-1845

The primary purposes for which management information systems (MIS) can be used in managed health care programs include:

1. To provide operational support, through claims and payments processing for example, for day-to-day business functions.
2. To provide management control, through accounting systems for example, for administrative monitoring and decision-making; and

3. To provide decision support, through utilization data reports for example, for administrative planning and evaluation.

Functions of MIS.

The main functions of management information systems include:

1. Actuarial analysis and underwriting for projecting utilization and cost for the purpose of budgeting and setting sound premium rates;
2. Administering group contracts and multiple plan options including billing premiums to employers;
3. Managing provider networks to maintain contractual relationships with participating providers and affiliated hospitals;
4. Processing claims and payments;
5. Planning and controlling finances;
6. Managing medical services and assuring quality, including admission precertification, second opinions, case management, etc.;
7. Providing member services including enrollment, eligibility verification, and general communications; and
8. Marketing and sales support.

Central Components of MIS.

To manage the above-listed functions, almost all of the management information systems used in managed health care programs consist of the following six central components:

1. Membership and eligibility data entry and tracking, which enables managed care organizations to enroll their membership, obtain and store demographic information, and verify ongoing eligibility;

2. Premium billing and accounts receivable processing;
3. Claims processmg;
4. General accounting;
5. Utilization management monitoring; and
6. Analysis and reporting for decision support.

Success Factors.

The terms Key Success Factor (KSF), or Critical Success Factor (CSF), are often used to describe the specifications, or key needs, which a managed health care organization is attempting to meet.

KSFs are generally established by teams representing different areas of the managed care organization. These teams identify success factors for their particular management area. Examples of KSFs include establishment and maintenance of accurate eligibility information, actuarially sound premium rates, or accurate payment of claims.

MIS Design Concents.

In designing an information system for a managed care organization, the following concepts should be considered.

1. Modularity. Typically, information systems are designed as sets of discrete software modules, each for a specific function within a health care plan. A complete information system will include a claims processing module, a premium billing module, etc. Any particular organization may need several modules, or only a few. The modules must be specific to the organization.

2. Flexibility. Because managed care evolves constantly, management information systems must be able to adapt to changes — in market demand, plan design, or management approaches.
3. Integration. This important design concept refers to a system's ability to link data from different modules. Not all systems are able to integrate data; some do so more readily than others.
4. New technology. Systems vary in their ability to incorporate new developments in technology. For example, as the capacity to increase data storage has increased, some systems have been more readily able to expand than have others.
5. Appropriate size and scope. The "fit" of a management information system should suit organizational needs. "One size" does not "fit all."

Guidelines for Assessing: Software Systems.

In evaluating the features of various information systems, a managed health care organization should:

1. Identify the essential current and future business functions which the MIS must support;
2. Evaluate and document the immediate and long-range needs of all users;
3. Define KSFs for each function based on a needs assessment survey performed within the organization;
4. Identify the relevant capabilities of alternative systems; and
5. Determine the need for possible modifications.

Software for Tribes.

Almost all existing software systems for managed care plans are for organizations that operate a complete HMO or PPO. Also, systems for hospital case management and precertification focus on reducing excess utilization.

Managed health care generally assumes that the patient population has access to care and thus focuses on identifying and reducing inappropriate care.

However, for tribal programs, excess utilization may not be a primary concern. Many tribal populations are struggling to ensure access to the most basic levels of care.

Thus, the MIS needs of a tribal program may be significantly different from those of non-tribal managed health care programs. The majority of existing software packages may have little relevancy for tribal organizations.

In addition, for tribes to individually evaluate and purchase managed care information systems wouldn't be practical. It could be more cost-effective for a single organization representing all the tribes' interests to buy software. United HealthCare, for example, purchases software for all of its participating HMOs.

Data Analysis for Utilization and Cost Evaluation

David Aquilina
Independent Consultant
4817 Vincent Avenue South
Minneapolis, MN 554 10-l 845

Primary Purposes of Data Analysis in Managed Health Care.

1. To quantify utilization and costs;
2. To manage and reduce utilization and costs;
3. To improve care management;
4. To provide medical management and provider education; and
5. To perform customer reporting.

Methods of Data Analysis.

There are two basic methods of data analysis.

1. Descriptive analysis or the "counting" of costs and services such as admissions, office visits or prescriptions.
2. Evaluation analysis, or performance assessment, through which patterns are compared to norms and standards.

   Assuming you have already tracked the numbers and dollars, evaluation analysis focuses on opportunities for improvement such as reducing the number of unnecessary procedures.

Standards or Norms.

Since there is an absence of agreement on standards in medical care, each organization must establish its own standards for what is appropriate versus inappropriate (or excessive) use. Overusage is a relative concept and often differs between organizations or even within the various departments of a single organization. Norms refer to statistical averages for various measures of use and costs.

Types of Reports.

The standard types of reports which are used by managed health care organizations include:

1. Demographic renorts which outline the general size of a covered population plus give information on members' age, sex, family structure and average contract size.
2. Benefit administration renorts which track the number of claims submitted and their total dollar amount and provide information on covered versus non-covered expenses, total allowed amounts and total cost-sharing amounts.
3. Utilization renorts which consist of descriptive analysis and provide, for example, an accounting of total numbers of admissions and lengths of stay; inpatient totals and rates by age, sex, and service; and total number of physician visits per member per year by specialty.
4. Costs reports which (a) track total costs by age, sex, inpatient/outpatient, medical service, and hospital admission and (b) provide total costs per member per month (PMPM).

Utilization Evaluation Reports.

These reports focus on assessing utilization and cost patterns in order to identify inappropriate patterns and to determine where there is room for improvement of care management.

Some typical indicators found in utilization evaluation reports include:

1. Admissions and inpatient days/rates versus the norm; and
2. Number of "suspect" cases (i.e., those exceeding the normal length of stay) within a particular diagnosis group versus a standard or norm.

It is relatively easy to count admissions, inpatient days and numbers of cases that HMOs have in a particular diagnosis group. However, trying to apply those figures against norms and standards to determine what percentage of cases are suspect is a much more difficult task. Yet herein lies a great opportunity to improve the management of care.

The managed health care organization can help this process through the use of good utilization management strategies. (See Monitoring Quality and Use of Services chapter, page 13.) For example, in a hospital admission involving low back pain, the managed health care organization — during the the precertification process — might ask the following:

1. Whether or not there has there been a previous trial of bedrest at home;
2. Whether the patient is taking any medications;
3. Whether there are any potentially complicating conditions in the management of this patient necessitating inpatient admission.

If precertification, as well as all other utilization management strategy systems, is in place in-terms of low back pain cases, then the appropriateness rate for that diagnosis should be good.

Quality Evaluation

David Aquilina
Independent Consultant
4817 Vincent Avenue South
Minneapolis, MN 554 10-l 845

Defining and Measuring: Quality.

Defining the concept of quality in managed health care is challenging. There is no single definition. Definitions will vary depending on type of care being evaluated (preventive care, acute care, etc.).

Keeping this in mind, quality can be defined as :

1. Appropriate care;
2. Technically effective care;
3. Care which conforms to standards and specifications;
4. Sound preventive care; and
5. Care which provides customer satisfaction.

Problems with Prevailing Approaches to Measuring Quality.

Most current efforts for measuring quality of health care focus on inpatient care and specifically on negative inpatient outcomes (such as patient mortality) to the exclusion of all other indicators.

There are several reasons for this. There are fewer hospitals than physicians, and inpatient data is more accessible. Inpatient data is more easily organized, managed, and analyzed. (We have ways of categorizing inpatient cases into roughly 470 diagnosis groups, giving us logical units of analysis.) Further, technologies exist which measure the severity of inpatient's illnesses in hospital. These technologies do not give information on quality and performance.

Because negative outcome rates are influenced by many variables, including the severity and mortality rate of the diagnostic group into which a patient's illness falls — and since negative outcomes are relatively rare, these rates alone are not truly useful measures of quality. That is not to say that negative outcome analysis is unimportant, however. To be effective, though, it must be focused.

Positive Direction for Quality Measurement and Management.

If quality is to be measured and managed effectively, we must adopt a broad set of definitions. These definitions should center on appropriateness but should also consider technical effectiveness, outcome of care, preventive care, and customer satisfaction.

Just as there is no one definition of quality, there is no one right way to measure performance.

Data is not useful in itself. It is not meaningful unless analysis translates it into information that guides and evaluates action and, subsequently, improves the quality of care. Translation of data into action is the key. The

managed health care organization must pose specific questions and must articulate the information it needs to evaluate specific programs.

Potentially Useful Data.

The data that would be useful for analyzing any specific program depends on that specific program. Each program must determine what information it needs and which questions to ask in order to get that information.

Demographic, primary care, and hospital claims data can be extremely useful. An example of their use is shown by looking at a teen prenatal care management program.

Demographic data can determine the program's target population. It can develop information profiles on that target — Who? How many? How many teenaged girls?

Primary care data can, not only pinpoint population groups, but identify specific individuals such as teenaged girls who have been in for a single health care visit but have not returned for follow-up.

Hospital claims data can help quantify costs.

Comparability Issues.

Counting units of utilization and analysis is not always an easy task. Some HMOs do not, for example, begin counting days of inpatient hospitalization for a newborn who stays on after his mother is discharged until after the mother is discharged. Others start counting days of inpatient hospitalization as soon as a baby is born.

Partial hospitalizations, or day treatments, also pose counting problems. Some organizations count day treatment patients as inpatients. Others count them as outpatients. For some, day treatment is a half-day; for other a full day. Some partial hospitalization cases are actually admitted.

Defining outpatient encounters is similarly challenging. Is an outpatient counted only if he sees a physician? Is he counted the same when he sees both a physician and a nurse? What if the patient is admitted for x-ray only?

Again, there is no one right or wrong way to define an encounter, but the managed health care organization must select and standardize a set of definitions so that its statistics are consistent.

IHS Managed Health Care

Mary Ramsey
Director
IHS Contract Health
Service Administration
Blue Cross-Blue Shield of New Mexico
Albuquerque, NM

Health Care Economic Environment and IHS.

1. MS is a large payor and must think like payor.
2. IHS is subject to the pressures of private marketplace.
3. Cost shifting is eroding IHS buying power in contract health services.
4. MS is subject to the causes of health care cost inflation in both direct and contract facilities.

5. Managed care principles can bring some understanding and control.

IHS has formed a Managed Care Advisory Committee to define feasible managed care policies for Indian communities. Blue Cross-Blue Shield of New Mexico is working closely with that Committee.

Education is critical. Eduate your staff on the goals and benefits. Present managed care as a partnership to allow more access to quality care. Concepts everyone is talking is the same language.

Look at starting small. There are lots of approaches and lots of pieces in managed care. Break it into what's "do-able" for you. Expend your resources where it will make a difference. Make someone accountable for analysis of your initiatives.

Basic Considerations for Managed Care and the IHS.

Small, sole-provider communities represent the greatest challenge for managed health care. These communities are the least likely to participate in networks such as Medicare and Medicaid. Tribal communities fall in this challenge category and IHS must be innovative as it explores managed care possibilities for tribal people.

One possibility at which IHS is looking is the concept of "piggy-backing" on managed health care networks which are already in place. In evaluating this possibility it is important to look at a tribe's present buying power and resources, considering existing direct care, contract health services and the availability of a direct care facility.

Although New Mexico's Blue Cross/Blue Shield (NMBCBS) does not presently contract to cover tribal health services, this possibility is being explored. Whether such an arrangement is feasible depends on individual tribal program needs.

If a specific tribal program approached NMBCBS stating, "We want to do things the same way the rest of IHS is doing them," then NMBCBS may be able to accommodate the tribe at a reasonable cost.

On the other hand, if the tribe asked NMBCBS to process claims in a unique manner (that is, issue checks imprinted with the tribe's logo or interface with the tribe's finance system) then the costs could be prohibitive.

Another practical way to begin exploring managed care options for tribes is to be sure tribal systems are in place for getting data to the IHS Albuquerque data center. This centralized IHS data system can help tribes increase their data collection and reporting by taking advantage of a system which is already designed and operating.

Piggybacking on the IHS central system could enhance a tribe's ability to capture detailed data. The tribe could have that data fed into IHS centrally, and then contract with someone to take that data from the central system and run it through programs specific to the tribe's unique needs. Increasing tribal capacity to collect more UB82 (hospital billing form) information is a good way to increase a tribe's available data base. Data must be compiled not only on contracted services but also on direct care. A tribe must have the same kind of information on what's happening at its direct care facility as it has for its contracted health care. Direct care costs may not have the same visibility in a tribe's budget, but — if not properly used — they too can erode buying power and resources.

Data may also help in looking at means of reducing costs. Should specialty MDs be hired to travel thru the area? Can preventive programs be put in place? Are there alternatives to hospital care?

Managed care is typically very centralized — with decisions being made centrally and from the top down. IHS, however, is a bottom-up organization. People in service units might buy into the managed care process, but the process won't work if front liners aren't committed to the concept.

Specific Recommendations.

1. Establish a network of managed health information in order to avoid individual tribes having to "reinventing the wheel." This could help prevent redundant efforts and save vital budget resources
2. Conduct small area analyses, focusing on step-by-step questions. It won't be possible to revamp entire programs overnight; it is best to evaluate and make recommendations for change "piece by piece."
3. Adequate contracting is key to success for the managed care organization. Providers must be prohibited from billing the patient for balances on authorized care or for care unauthorized by IHS or for care found to be inappropriate.
4. Be creative, but cautious, in setting up reimbursement methods. Assure that reimbursement agreements benefit your organization. Don't contract for a method of reimbursement that will cost more to administer than it will save in program dollars. Recognize that health care is a business, especially for hospitals. They will therefore enter negotiations well-prepared and will cut hard deals. Be aware of your options.
5. It is crucial to all managed care organizations that appropriateness of service and utilization reviews not only be performed, but that they be acted upon.
6. When entering cost negotiations, never lose sight of quality assurance obligations.
7. Use consolidated bargaining power where possible. In many cases, MS/tribes are a larger payor. Use that clout in contracting.

Delivery Issues.

1. Should the health care organization hire or contract out for needed services? There are advantages and disadvantages to both options, depending upon the patient population and on available capital. The larger the membership, the more cost-efficient it might be to have a neurosurgeon or cardiologist on staff. It may be more efficient to mix options by hiring a cardiologist but contracting out to a cardiovascular surgeon.
2. What is the availability of providers in the community, not only in terms of numbers but scope? Identify MDs, midwives, public health nurses, physician assistants, etc. Determine which services you need and match them to the appropriate providers.
3. What is the quality, accessibility, and cost of available providers?
   a. Quality. Provider quality can be assessed in terms of facilities, staffing and staff credentials. It should be measured in terms of process. What do providers do to assure. quality care? How well do they chart patient encounters? What information does the provider collect? Is it up-to-date? (It is not unreasonable to ask to review medical charts.) Do providers have a process by which they review each other's quality?

      It is virtually impossible to measure providers' actual case outcomes, especially in private practice. The managed care organization should try to set up an agreement whereby the physician or practitioner is held accountable for reporting outcomes.

   b. Accessibility. Questions to be asked include: Can disabled patients physically access clinic? Are clinics, hospitals, and provider offices located near people's homes and workplaces?

      Often, there are tradeoffs between access and cost. If you concentrate more business into one or two clinics, you may be able to get better financial arrangements.

   c. Cost. Information on the costs of providers is readily available from a number of sources. Ask the providers themselves to

make their fee schedules available. Access public information; often, Medicare or other state offices have cost reports and other information about providers' fees. Where hospitals are public entities, they must make this information available to you under the Freedom of Information Act.

Once you have gathered quality, accessibility and cost information, you are in a position to begin negotiating with providers.

In addition to discussing cost, you should look at what a provider is willing to arrange in terms of financial reimbursement. Some physicians and hospitals are willing to discount their fees if patient volume is high enough.

Financial Issues.

The following steps will assist the health care organization in managing financial risk: develop reasonable contracts; make separate payment arrangements for in/out patient services; individually tailor payments for specific physicians/services; and require financial and provider accountability_

1. Develop reasonable contracts.
   a. Include provisions which protect against under/over-utilization of services.

      Straight capitation arrangements invite underutilization. In a straight capitation arrangement, a managed care organization gives a certain amount of money per person per month to a group of physicians which agrees to provide specified health services to the organization's members. The providers thus function like an insurance company in that they are responsible for all the costs associated with the patient population's use of the specified services. However, unless providers are experienced and have the financial resources to safely cover the risks,

capitation arrangements can result in patients' being denied needed services.

On the other hand, contracts should not result in over-utilization where providers wind up providing more services than appropriate.

Contracts should include a structure that neutralizes. Salary payment to providers is probably one of the most neutral arrangements.

b. Include provisions which make providers accountable for the outcome and costs of their services. Require providers to report their experience with patients. There are forms available which are widely used for this. They include, for example, UB 82 forms from hospitals and 1500 forms from physicians.

c. Offer a fair, reasonable payment schedule.

Under no circumstances should you consider cutting back reimbursements to providers. A poor relationship with providers ultimately affects your member population.

d. Make sure your payment method reflects the actual resource use or the actual cost that the provider incurred in caring for the patient.

e. Keep your financial arrangement administratively simple, so that payment can be made in a timely and accurate manner.

2. Separate in/outpatient payments.

a. Make separate financial arrangements for inpatient and outpatient services.

b. Hospital costs are rising most rapidly in outpatient treatment where services are being increasingly performed. Try to establish fixed reimbursement arrangements with hospitals in order to maintain some control over outpatient costs.

c. On the inpatient side, have the hospital assume some financial risk by fixing fees on either a per diem or a per stay basis.

(Some hospitals avoid fixed-fee agreements, preferring bill charges or discounts on bill charges.)

d. Review alternate payment methods. (See "Hospital Risk Exposure by Type of Contract" in APPENDIX D.) The following are some of the more common reimbursement options available.

1) Routine Bill Charges. A fee for-service arrangement in which the hospital assumes no risk whatsoever.

2) Discounted Bill Charges. A fee-for-service arrangement by which the hospital agrees to reduce charges by a specified percentage. Example: You agree on a 10% discount from billed charges and an 8% inflation rate for medical care. The hospital increases its bill charges by 10%. You get to add the difference between the agreed on and the actual inflation rate (2%) to your discount. This equals a 12% discount. That way, you will have countered the inflation increase in billed charges.

3) Per Diem Payment Method. A fee-for-service arrangement by which a flat daily rate covers routine and ancillary services. The flat rate will vary by service category (medical, surgical, psychiatric, obstetrical, neonatal). Per diem arrangements are advantageous to the managed care organization when it is able to keep the length of stay down.

4) Per Case Payment Method. An arrangement in which costs are set for specific diagnoses and are fixed by case.

Where the health care organization's influence is limited, it is best to go with a per case payment. For example, in cardiovascular, transplant, or other "big ticket" cases, the managed care organization generally has limited influence and it is best to arrange reimbursement on a per case basis.

Per diem and per stay rates should be all-inclusive, so that there is no guessing about liability.

5) Capitation. A method whereby a single rate is set per member per month and pre-paid to cover all inpatient care provided. Few hospitals agree to this method as they are not willing to assume the risk involved. Future legislation may prohibit these arrangements altogether.

Capitation arrangements, however, are still being made in some areas. In considering this method of payment, carefully define your population and define specific hospital service responsibilities.

6) Percent of Premium. A method in which the plan pre-pays a set percentage of premiums to the hospital for defined inpatient services. Differs from capitation in that a flat fee is paid. Again, the hospital assumes most of the financial risk.

e. Try to arrange for fixed, all-inclusive rates for each possible outpatient procedure or service, especially surgery.

Medicare divides outpatient surgical procedures into six to eight Outpatient Surgical Groupings, based on anticipated cost. Consider using these groupings as a guide when negotiating fixed outpatient rates.

Alternatively, make a list of the 25 most common outpatient surgical procedures and negotiate a cost for each. Make sure your coding system is consistent and efficient.

Outpatient services such as emergency room or physical therapy are more complex to negotiate. A sound way to arrange reimbursement of these services is through straight billing or discounted bill charges. It would be nearly impossible to establish an emergency room per case rate.

When emergency room patients are admitted to the hospital, make sure emergency room costs are not paid in addition to per diem or per case rates. Make sure emergency room costs are folded into per diem or per case rates.

f. Consider multi-year contracts which include a defined adjustor for inflation.

g. Consider sharing risk between the managed care organization and the hospital.

By definition, managed care organizations and hospitals have conflicting incentives; hospitals would like to fill all of their beds, while managed care systems would like to empty them. Risk can be shared around length of stay .If the length of stay is above the norm, the managed care organization and the hospital split the difference in charges; if it is less than the norm, they split the savings.

Another option is to negotiate for staged per diem arrangements, whereby the, greatest amount per case is paid for the first day of stay. The per diem decreases for each subsequent day of hospital stay.

3. Tailor payment methods to individual services and physicians. Physicians can be encouraged to care for patients in an effective and efficient manner through contract incentives (see Kind of Delivery System in APPENDIX E for a description of payment methods and incentives by various physician/association arrangements.)

There are three general options: fee-for-service, capitation or salary. Fee-for-service and capitation can be combined especially for small clinics which can't take on straight capitation. In these cases, payment is on a capitated basis, but the clinic is guaranteed reimbursement which, at at the end of the year, will not go below a certain percentage of its fee schedule.

Negotiating Fees

In negotiating fees for service, the managed care organization has the following options.

a. Discount from the physician's fee schedule. This is one of the easiest ways for your system to work.

b. Develop a usual and customary fee schedule by setting rates for each diagnosis and/or procedure based upon what is usual, customary, and reasonable. This is difficult to establish, especially when the managed care organization does not have sufficient experience.

c. Develop a fixed fee schedule. This is often the best approach, since it allows the managed care organization to control increases per year. The drawback is that such schedules may involve a great number of billing codes and thus be complex to administer.

Fixed Payment Options

Fixed payment options, besides capitation, include retainer arrangements and per unit arrangements.

a. Retainer arrangements are a contracted salary arrangement, by which you pay a certain amount per month to the provider, irrespective of the population to be served. For example, $50,000 a month will be paid to anesthesiology for whatever services they provide. You then have incentive to bring more and more service to that hospital. Retainer fees may be adjusted, and are best suited to anesthesiology or other services which are easy to predict over time.

b. Per unit arrangements, by which the managed care system pays per hour.

4. Require Additional Financial Accountability.

   a. Claims systems should accurately pay for appropriate services in an efficient, timely manner. Ail large bills should be reviewed for error. The managed care organization may opt to hire someone to operate the claims system in exchange for **a** percentage of the claims.

   b. Cash should be paid out on a timely basis (two to four weeks).

   c. Medical authorization and referral systems should be established to assure appropriateness of medical claims. Provider claims should be linked to whomever authorized the service.

   d. Provider fee schedules and code techniques should be regulated. Providers, for example, may code for higher reimbursement by changing "brief visits" to "intermediate visits" or by changing their diagnosis codes. If any significant changes in billing schedules or coding are noticed, the provider should be challenged.

5. Assure Provider Accountability.

   A managed care organization may opt to include the following in its provider contracts:

   a. Require continuous licensing and certification of providers.

   b. Prohibit any form of discrimination or access denial by providers.

   c. Require contracted providers to cooperate with organization's quality assurance and utilization management systems by allowing access to their records.

   d. Require providers to support organization's quality assurance and utilization management efforts by reporting all necessary medical and financial information.

   e. Seek legal assurances by providers (such as liability insurance) to assure that organization is not held liable for provider's negligence. Though the managed care organization may be named

in legal cases, such assurances as liability insurance will normally hold up in court.

f. Clearly define services to be provided and population to be served.

Contract Development Suggestions

1. See "Contract Evaluation Checklist," APPENDIX F, for provisions which should be included in contract.
2. Consider developing a contract abstract or review form (see APPENDIX G) for each individual contract. The abstracts can be filed and referred to as an alternative to leafing through long contracts.
3. Develop a contract manual for providers and others (such as utilization reviewers) with an interest in the contract. (See APPENDIX H for an outline of steps to be followed in developing the contract and for what to include in the manual.)

Risk-Sharing

Ramona Omelas
Chief, Policy Analysis Branch
Office of Planning, Evaluation & Legislation
MS Headquarters

Risk-sharing is an issue that needs evaluation. Currently, the private sector is not asked to share any of the risks relating to Indian health. The tribes or IHS assume the full burden. Third-party reimbursement may be sought but is rarely obtained.

At present, federal dollars may not be used to purchase indemnity (insurance) plans for Indian health. This may change. A legislative proposal has been made — but has not cleared OMB yet — that would allow tribes to purchase insurance plans with federal doilars.

Medicaid/Medicare-eligible enrolled tribal members are not being reimbursed for care provided by IHS or Tribes. The State of Arizona, for example, has refused to provide reimbursement through its Medicaid/Medicare HCFA programs for Medically Needy/Medically Indigent Indians who reside on reservations.

IHS Analysis of Arizona Medicaid Program.

In response, IHS has contracted an Indian firm to analyze Medicaid's responsibility for services provided to American Indians who are eligible for both IHS and Medicaid/Medicare services.

The analysis focuses on ACCESS (Arizona Health Care Cost Containment System), the Arizona Medicaid program. It is following a preliminary study which showed that the Navajo Area IHS was eligible for some $19 million in Medicaid reimbursements but, because it is a federal entity, it could not obtain this reimbursement.

The Arizona study, still in its early stages, focuses on access and risk issues:

Access Issues

The study is analyzing:

a) Possibilities for II-IS access to Medicaid resources through statutes and regulations providing for direct billing of fee-for-service costs to State Medical Assistance Plans;

b) Methods and procedures which provide access for IHS to Medicaid reimbursement:

c) Medicaid categories and eligibilities in relation to Fiscal Intermediary payments processing;

d) Statutes, regulations, and procedures pertaining to tribal contractor access to Medicaid resources via IHS;

e) Tribal coordination with State Medical Assistance Plans.

Risk Issues

The study is analyzing Cavitated Risk Contracting by reviewing: (1) sources of risk, (2) cost accounting, (3) cost allocation, and (4) financial management system requirements necessary to minimize financial risk.

The study is also analyzing Anti-Deficiency Act Risk Avoidance. This includes analysis of: (1) discretionary and entitlement program anti-deficiency budget expenditure requirements and (2) procurement methods which minimize risk.

Tulalip Risk-Sharing Study

Linda Jones
Service Manager
Tulalip Board of Directors
Marysville, WA

The Tulalip Tribe is in the Portland IHS Area, located approximately thirty miles north of Seattle. It is one of twelve Puget Sound Service Unit Tribes. Currently, the Tribe has an enrollment of 2,300 people.

The Tulalip health care organization is a tribally-owned health clinic with a user population of 1,700 members. It has no hospitals or clinics and has utilized some 200 health care vendors since 1987. Tulalip has maternal child health and CHR contracts with the IHS. Its newly-installed automated billing system is still collecting preliminary data and is not yet capable of providing long-term study data.

The Tulalip Tribe is a large employer, with approximately 300 full-time employees, 200 of whom are tribal members covered under private insurance.

Tulalip offers two insurance options to its employees: 1) an HMO, which covers all health care costs, with some copayments and deductibles; and 2) a partially self-insured plan.

Like many other organizations, Tulalip has experienced difficulties in coordinating health resources particularly in the area of billing, the responsibility for which it had contracted to MS. Patient bills were frequently not paid on time and their accounts were sent to collection. Subsequently, providers would often refuse to see these patients.

Tulalip has identified the problem as being one of coordinating resources.

If, for example, a patient has ever been Medicaid/Medicare eligible or has ever had private insurance, he is recorded in the IHS system as having other resources — even after these have expired. The bills of people who are noted as having "other resources" are referred back to the provider. This causes lengthy delays in payment and reluctance to utilize the system. As a result, some Tulalip tribal members do not tell IHS if they have private insurance. Others fully utilize private insurance and get MS to cover the copayments. Still others don't report at all.

Risk-Sharing; Study.

Two years ago, IHS approached Tulalip to propose a risk-sharing study. It targeted the Tulalip Tribe because the latter was successfully providing private insurance for its employees and because Tulalip was dissatisfied with the IHS billing system.

Tulalip agreed to participate in the study, believing it would be a good way to automate its clinic, which at the time was still compiling its data manually. Currently, Tulalip is in the data gathering stage of the study.

The data collection phase of the Tulalip study involves gathering data on population and utilization of health care from a number of sources. This is time-consuming as there are difficulties in searching out sources.

After data gathering and analysis have been completed, the Tribe hopes to be able to effectively combine resources to provide all-encompassing quality health care, including preventive care. The Tribe also hopes to see a substantial reduction in the numbers of members currently on deferred services lists. Tulalip believes these to be realistic goals.

In the State of Washington, recognized tribes have signed an agreement known as the Tribal State Accord. This recognizes the sovereign status of individual tribes and affirms that the relationship between the State and a tribe is one of government to government.

Tulalip feels the Accord strengthens the Tribe's position for obtaining increased access to needed programs.

Tulalip is hoping to create a comprehensive health plan which would be funded by a combination of IHS, tribal, and Medicare/Medicaid dollars.

Suquamish Health Care

Lisa Giles
Medical Social Worker
Suquamish Tribe, WA

The Suquamish Tribe is located in the Portland IHS Area where there are no hospitals for Indian people. Thus, primary care for Indian communities is provided either in tribal health clinics or through contract health care.

The Suquamish Tribe is located about an hour's distance from Seattle, across the Puget Sound. Only 450 of its 750 enrolled members actually live in-county. Of those, 375 are covered by the Suquamish health care program; 60 others receive Aid to Families with Dependent Children (AFDC) or Medicaid and thus are not included by the tribe's arrangement with Network Management Program. (See page 67 for a description of this program.)

Years ago, because a great number of the health claims for tribal members were going unpaid and bills were frequently sent to collection, doctors were unwilling to see Suquamish patients.

To correct these problems, the Suquamish negotiated with Blue Cross of Washington and Alaska (BCWA) which signed an "Administrative Services Only" contract with the tribe. The contract called for the tribe to pay BCWA a monthly fee to cover the cost of processing claims plus an additional set amount per person. The Suquamish maintained that contract for over two years until subsequent rate increases forced them to look at other contracting options.

The Suquamish contracted with Network Management, Incorporated, a local insurance company which manages a variety of self-funded health care programs. Under the Suquamish system, tribal members are issued a

health card to present to providers. They enjoy a defined set of benefits and choose their own physicians. Preauthoriztion is required for hospital care and second opinions are required for certain in/outpatient surgeries. As with any IHS-funded health care contract, this program is secondary to all alternate resources. Clinics are willing to see Suquamish patients because they can rely on timely payment.

Present Onerations of Suauamish Svstem.

Every two weeks, the Suquamish Tribe receives from Network Management a list of claims processed during the previous two weeks, along with their invoices. Suquamish sends its purchase orders to accounting, which cuts a check and sends it to NMI. There, health claims are paid and checks are released to providers. Suquamish also sends biweekly invoices to the Area IHS Office.

If tribal members get bills or letters from NMI requesting information, members tend not to answer. NMI has established the following procedure. It will send out two letters, then deny the claim until it receives the information requested. Hopefully, this system will encourage members to respond promptly to such queries.

In addition to monthly financial status reports, NMI reports costs every six months on six different items: the average monthly cost for paid claims; surgical claims by place of service (in/outpatient); coordination of benefits and UCR savings; hospital utilization; how long it takes to process claims; and suggested reserves for lag claims.

One advantage of the Suquamish's relationship with NMI is that the Tribe can take advantage of NMI's expertise and technology in claims processing, data management, and provider relations. NMI cost and comparison reports are very helpful to the Suquamish.

Tribal Member Attitudes.

The Suquamish Tribe has conducted informal surveys of its members over the past several years on a variety of issues. Two years ago, in a risk-sharing study, tribal members were asked:

> If we can fiid a medical plan for the Suquamish Tribe which would serve all of your health care needs, would you be willing to change your physician for HMO or PPO arrangements?

Seventy-three percent of those surveyed, answered "YES."

In 1990, the Suquamish again surveyed its members in order to get a clearer indication of member preferences. Three answer options were available.

a) I feel I must see my primary doctor and will wait until he or she is available;

b) I feel it is important to see my primary doctor but will see another to get help more quickly;

c) I don't care whether I see my doctor or another, as long as I get medical care.

Fifty-nine percent of those surveyed answered b) and c) in the affirmative. The remaining 41% preferred to see their own physicians.

Tribal Interest in Risk-Sharing.

The Suquarnish Tribe became involved in the recent risk-sharing study because it is interested in options other than third party administration.

Several years ago, the Tribe employed an insurance broker to survey other county HMOs or PPOs which might be interested in cooperative risk sharing. The other organizations responded that they were not interested in

the Suquamish program since it did not represent an employer/employee relationship.

Currently, the Tribe is gathering tribal-specific data for analysis, and hopes to again explore the possibility of risk-sharing arrangements with area organizations.

Identifying Alternate Resources.

Because Network Management Inc. has been paying the Suquamish bills for the past three years, it has acquired a bank of information about processed claims. The Suquamish plan to use this data to compare what is billed and what has been paid. From those figures, the Tribe can determine what alternative resources are being utilized.

An Actuary's Assessment

Sarah S. Plotkin
Consultant/Actuary
TPF & C
Seattle, WA

The speaker is an actuary, a profession she defines as follows.

An actuary is one who estimates the probability and economic impact of future events. For example, an actuary may predict what the chance is that someone who retires today will live for 20 years and collect social security checks...or, die and leave a survivor who will collect survivor payments.

Essentially, an actuary's job is to explore the range of possibilities and quantify the expected outcome.

Actuaries can be found in government offices, such as the Social Security Administration, insurance companies, and consulting firms dealing with risk management and employee benefits. All actuaries have the same basic skills, but specialize in differing areas.

Actuarial Roles in Risk-Sharing Studies.

An actuary generally participates in six phases of a risk-sharing study. These include: data collection; data analysis; benefit design; selection of delivery system; cost forecasting; and reporting.

Data Collection

In the case of the Suquamish and Tulalip risk-sharing studies, the actuary's role in data collection has been limited to designing the collection format. Actual collection — which generally takes more time than anticipated — was done by graduate students.

Data Analysis

Data analysis includes looking at demographics, asking who will be covered to determine what kinds of health care services are needed. It also involves determining the costs of services (such as room and board or outpatient visits) and identifying utilization patterns. What kinds of services (medical, surgical, inpatient, outpatient) are used? What are the number of visits and admissions? What lengths of stay are involved?

An actuary will help determine what services are being used, which are valued, and what services might be cut.

Benefit Design

A tribe cannot provide all services to all its members on IHS funds. The actuary wiil help define which benefits can, and should, be offered within cost limits. The actuary will also help decide whether cost-sharing (such as copayments or deductibles) will be necessary.

Selection of Delivery System

The actuary will help a tribe find the best service delivery system arrangement for its situation. The following alternatives may be considered: fee-for-service, preferred provider discounts, or capitation arrangements. Or combinations of these may be arranged.

The choice is based on determining who is, or should be, bearing the risk. The IHS, insurance companies, the providers themselves, the tribes, and tribal members may all share risk.

Forecasting Plan Costs

After determining what services should be provided, to whom, the actuary will help the tribe draft a preliminary benefit package including an estimate of what it all might cost.

At this stage of actuarial analysis, the cost estimate is taken to providers and negotiated. If they say no, the actuary goes back and adjusts copayments, etc.

Production of a Report

Once the benefit package is set up, the actuary will produce a final report summarizing data and making recommendations on the feasibility of

the risk-sharing arrangement. The actuary will design the report according to tribal needs, taking into account its various audiences_

Unbundled Health Care Management Services

Jan Malcolm
Vice President,
Policy and Development
Group Health, Inc.
Minneapolis, MN

Definition of Unbundled Health Care Management Services.

Unbundling refers to the fact that both the management and the delivery of health services may now be purchased in partial packages.

A purchasing organization can, for example, contract with one or more health care provider systems for individual, specific services (utilization management, provider contracting, mental health, pharmacy or laboratory services, for example).

This allows the purchasing organization — which chooses to manage its own health care — to "farm out" certain services and perform others in-house. It also allows an organization purchasing health care to take more control by (1) assuming financial risk and (2) customizing both the package of provided services and the provider network(s) delivering specific services.

Recently, health care purchasers are choosing to hold more financial risk: self-insuring and paying out as claims are incurred rather than paying a premium up-front to an insurer to transfer the financial risk. This makes

sense because of the cash flow implications: purchasers keep the profit that insurance companies would make and instead contract out to a number of private vendors to provide specific services (pharmaceutical, mental health, laboratory, etc.).

Recognizing these trends, a growing number of health care systems are unbundling their services, so that purchasers have the option of negotiating contracts for any combination — partial through full — of their health care services.

Availability of Unbundled Services.

Forty-two percent of recently studied managed health care organizations sell third party administration (TPA) services, whereby the purchaser self-insures- the medical services used and the TPA pays the claims and administers the benefits. Statistics show that as many as half of all HMOs sell unbundled utilization review services.

Advantages to Unbundling Services.

A decided advantage to unbundling is that it allows a particular health care system or other vendor to provide a greater level of expertise in a narrower field. It is difficult for any single system or vendor to be competent in all health care fields; it is significantly easier to develop sophistication in selected fields.

For the purchaser, buying services on an unbundled basis allows the purchaser to focus on specific problem areas of health care delivery.

Disadvantages to Unbundling Services.

When a managed health care organization fragments off pieces of its total product, it breaks the cohesion of its system.

Another drawback to unbundling is the decentralization of information. The managed care organization, which offers or purchases unbundled services, becomes dependent upon others outside its system for valuable information.

Additionally, by subjecting the patient population to a large number of decentralized vendors, the purchasing health care organization runs the risk of putting its members through frequent system changes.

Contracting: for Unbundled Utilization Management Services.

Many organizations which purchase health care services are contracting with outside vendors to perform their utilization management functions. Vendors selling utilization management services are available to perform all of the services listed below.

1. Build provider networks. (Utilization management service vendors can credential and accredit providers, assuring that the providers are licensed and don't have histories of malpractice.)
2. Manage patient referrals.
3. Precertify in- and out-patient services.
4. Manage high cost, catastrophic medical cases (e.g., AIDS, Stroke, etc).
5. Conduct on-site, or telephone, concurrent reviews.
6. Perform discharge planning.
7. Develop medical appropriateness policies.
8. Administer claims adjudication.

9. Perform protocol-based reviews.
10. Report data.

Why Contract?

At a time when many managed health care organizations are having trouble covering medical costs, they might well wonder why they should further stretch tight resources to contract for utilization management services.

The goal in contracting with utilization management vendors should be to replace costs, not add them. Dollars paid to utilization management vendors should help stretch resources through improved management. Vendors should not add financial risk — they should reduce risk, either by reducing a purchaser's costs directly or by accepting risk themselves to deliver all needed services for a pre-set price.

Negotiating for Utilization Management Services

Vendors may differ substantially in their methods of utilization management. On negotiating for utilization management services, the following questions should be discussed.

1. Are reviews conducted on-site or by telephone? Which method better suits your system? (This depends on the level of control you prefer to exert.)
2. Does the vendor have a paper or electronic system?
3. Does the vendor employ clerical staff or RNs and physicians to perform utilization review tasks?
4. Does the vendor simply offer tracking services or will it help manage problem areas for you?

5. What is the vendor's style of dealing with providers? Are criteria and protocols secret or open? (There are advantages to both. Ideally, a system should be credible but somewhat confidential so that providers cannot manipulate it.)

The following lists tasks which utilization management vendors may be expected to perform.

1. Vendors should demonstrate defined medical policies and show how these were decided upon.
2. Vendors should define screening criteria and show how these were selected.
3. Vendors should demonstrate which types of data collection tools they use.
4. Vendors should do system implementation for you. They should not only design the system, but put it into place.
5. Vendors should design means for interfacing new policies and procedures with those already in place.
6. Vendors should provide training materials and programs for your staff. (Discuss how the vendor will communicate changes to your staff and physicians.)
7. Vendors should have a pre-designed package of management data reports which they can tailor to your specific needs.

Unbundled Pharmacy Management Services.

Pharmacy management is a large industry which has grown out of the rising cost of pharmaceuticals.

An organization providing managed health care must control its pharmaceutical costs and must determine for which drugs it will provide reimbursement.

A pharmacy management vendor can impact an organization's pharmaceutical costs by providing the following services.

1. Building you a pharmaceutical supply network by helping you develop contractual relationships with selected pharmacy providers in your region.
2. Managing that network, helping you maintain relationships with providers.
3. Working with you to decide on (and then publishing and distributing to physicians and pharmacists) a specific list of those drugs which are reimbursable and those which are not.
4. Performing drug utilization reviews, to determine appropriateness of prescribing and use.
5. Providing a system for pharmacy claims payment.
6. Producing management reports and profiles on patients and physicians.
7. Educating physicians and intervening in their practices.
8. Negotiating volume discounts with pharmaceuticals' manufacturers; rewarding companies for quality and reasonably-priced drugs.
9. Accepting financial risk, including risk for increases in the cost and volume of drugs, through capitated arrangements.

Unbundled Mental Health/Chemical Dependency Services

Current Situation

The costs of providing mental health and chemical dependency services have also risen drastically.

Total mental health and substance abuse claims now account for between 15 to 20% of total claim costs.

Ninety percent of hospital admissions for these services are classified as emergency. This implies poor outpatient management and preventive services since admissions should be planned as part of treatment.

In addition, there is a lack of standards for diagnosing and treating mental health and chemical dependency cases. It is presently difficult to categorize the severity and risk of these conditions.

HMOs are sometimes criticized for inadequate handling of mental health and chemical dependency cases. Frequently, an HMO's benefits are designed to be short-term and crisis-oriented. HMOs have also been accused of being unresponsive to mental health emergencies.

Improving Services

A managed care organization may often improve its mental health and chemical dependency treatment program by contracting for specific mental health/chemical dependence services.

Mental health/chemical dependency vendors offer the following services.

1. Perform needs assessments to determine what areas of mental health or substance abuse need attention. These often vary by area and may include problems involving adolescents, chemically dependent mothers, or suicide, for example.
2. Perform credentialing, contracting, and reimbursement of providers.
3. Manage provider networks through education and reporting.
4. Offer utilization management procedures such as determining lengths of stay for specific diagnoses and structuring outpatient courses.

5. Pay claims.
6. Perform data analysis and report findings.
7. Help to manage financial risk on one of three models:
   a. Vender assumes all risk through a capitation;
   b. Vendor creates the provider network (with negotiated reimbursement terms) while purchaser continues to pay claims;
   c. Independent review, whereby a management company does all intakes, case assessment, and treatment planning and refers for specifically-ordered outside care.

Transplants and High Tech Care.

Transplants are probably the most familiar example of high tech care; and significant health care system's resources can be spent on them. Health care providers are, therefore, faced with the question of whether to provide costly services to a select few patients or basic health care to many. Across the industry, there have been substantial increases in the use of high tech services due to greater patient awareness and demands.

Assuming that a managed health care organization includes transplants and other high tech care in its covered benefit package, how can it assure that these services are provided in an effective manner?

Facilities which perform specific high cost, high tech procedures have developed. These are called "Centers of Excellence."

Some of the specific kinds of services that are offered by these Centers of Excellence are: transplants; coronary artery bypass grafts and angioplasty; brain and spinal cord injury rehabilitation; neurosurgical procedures; and trauma bum procedures.

Managed care organizations which are considering contracting with a "center of excellence"-should carefully review the center's volume, cost and outcome records.

Volume is important because centers which perform many high tech procedures generally charge less for them; conversely, those which perform fewer procedures generally charge more. Major institutions often offer discounts to purchasers (of as much as 30%) in exchange for exclusive provider rights for a procedure. When discussing a $30,000 procedure, such a discount is significant.

Cost, however should not be the only factor considered: the purchaser should focus on those facilities with the best patient outcomes. Large centers often offer proven providers, and, most importantly, work with the purchaser in deciding criteria protocols.

Negotiating for Unbundled Services.

As tribes negotiate for unbundled services, they should consult one another and other health services purchasers to assess a potential vendor's attractiveness. Tribes might maximize their negotiating positions by exploring joint contracting among tribes in order to conserve resources and avoid redundancies in effort.

Portland Area Study and Managed Care Initiative

Marie Moses
Acting Director, CHS
Portland Area MS

Study of Contracting Methods.

The Portland Area has recently undertaken a study to look at payment methodologies and determine whether it would be possible to negotiate prepaid arrangements or discount rates with high-volume health care providers. The study was initiated after a review by the Office of Health Assistant Secretary of, Health which pointed up the need for improved methods of contracting with more health care providers.

A health services contracting specialist was hired to research methods for contracting health services. Her first task was to examine current provider contracts to determine whether individual contracts should be extended, renewed or dropped. Working with the Portland Area Managed Care Coordinator, the specialist found that many contracts should be let go and reintroduced on fresh terms.

The study also examined creative alternatives to reaching agreement with providers, focusing on volume and quality. One idea explored was the idea that tribal programs may be able to "piggyback" on future IHS contracts.

Also investigated was the concept of developing a networking system between IHS Areas. This system would function as a "clearinghouse" and its contracts would be useful to tribes in all Areas. For example, if a travelling beneficiary is in need of care in an Area outside his own IHS Area, he would be able to check into a contract facility in that Area rather than have, as he now must, emergency care at the open market price.

The Portland Area study team is also developing a "boilerplate" solicitation for seeking proposals for contract inpatient care (on which the Area presently spends 34% of its contract health budget).

In addition, the Portland study is evaluating outpatient provider contracts, laboratory x-ray contracts, eyeglass contracts, etc. Contract models will be developed and the study specialist will arrange a series of site visits for the purpose of negotiating contracts in person.

The study recommends that clinical personnel accompany administrative personnel to contract negotiations with providers. The clinical personnel are important for discussing the medical practice questions which come up. It is also suggested that tribal representatives be part of the negotiation process.

Managed Care Initiative.

Because the Portland Area IHS has no inpatient facility, most of its ambulatory care must be referred out. As a result, the Portland Area contracts with a large number of providers. With limited funds and rising service costs, the Area has become increasingly hard-pressed to provide consistent, high quality health care services to its patient population.

In response, the Portland Area convened a task force in February 1990 to develop a comprehensive model of health care services. A Managed Care Initiative was drafted. It consists of the following components.

1. Utilization Management.

   Portland has two ways of referring patients out. In the first, the patient comes to a clinic, is screened, seen by physician, and referred to specialty or inpatient care.

In the second, a beneficiary, who is unable to come to a clinic because of geographic distance, calls in and receives authorization to see a physician.

The Task Force developed a utilization management model which employs a trained case manager who authorizes care, communicates with providers, and conducts concurrent reviews for cases in which patients are admitted to a hospital. The case manager also does discharge planning and follow up. The benefit to this model is that the provider and patient both have a contact in IHS.

The Task Force recommends that the case manager be a nurse.

2. Medicine and Supplies.

Medicine and supplies are two of the high cost areas in health care finance. There are several ways in which the cost can be managed without sacrificing quality. For an example, instead of paying full market price for medicine which is used for chronic or recurrent conditions, it is possible to dispense it at a discount by reaching an agreement with a pharmacy or several pharmacies.

3. Restructuring Contract Health Service Program.

The Task Force is exploring possibilities for updating the CHS program to meet current needs.

One consideration is the need to review functions and grade levels of CHS administrative personnel to ensure that job descriptions are consistent with grade levels and that nonmedical personnel do not make medical decisions.

Another possibility which is being strongly considered is centralization of some CHS functions (such as authorization or precertification) into a service center which can provide service authorizations during off hours.

When clinics are closed, many patients go to an emergency room. This results in high emergency room charges. An "800" telephone line — "Dial-A-Nurse" — might cut down on these charges.

Also being considered for centralization are case management and bill paying.

CONCLUSION

A great deal of information was presented over the course of the Managed Health Care Strategies Workshop. Hopefully, it has provided trainees with some tools and approaches which they can incorporate, as efficiency measures, into their local programs.

We have not intended that tribes and Indian communities turn their health programs into managed care. Rather, we are hoping that some of the elements and management tools used by Managed Care Organizations can be adapted to the needs of particular programs. Increasing quality of care while lessening costs is an objective for which all our programs should be striving.

We hope, too, that this training will help tribal and Indian community health care personnel to evaluate their programs and articulate their needs. The training and technical assistance needs expressed here will be compiled and provided to IHS policy makers and the report of this meeting will be widely circulated.

The following are questions raised by training participants through the course of the workshop. Some of these questions have been answered. Others will be responded to in the future. Future training workshops may be planned with these questions in mind.

The questions are grouped in general categories including those relating to: suitability of managed care concepts to tribes; implementing managed care concepts within tribal communities; financing health care; recordkeeping and information systems.

Suitability of Managed Care Concepts.

- What size population is necessary before managed health care becomes a feasible option?
- Is the creation of tribal health care consortia, through grouping small tribes together, a feasible means for obtaining the patient volume necessary for managed health care programs?
- To avoid each tribe's having to start on the ground floor, in negotiating contracts with local hospitals and providers, could IHS develop a procedure which tribes could adapt?
- If managed care methods are undertaken, how should the Native American health care organization work with communities adjacent to the reservation or Indian community?
- How should it work with rural monopolies?

Implementing Managed Care Concepts.

- How, and what, managed care concepts can tribes and Indian communities implement?
- What kinds of qualifications are necessary for the managers of tribal health care programs utilizing managed care concepts?
- How should service limitations be determined in light of politics?
- What kind of service gaps might be caused by the introduction of HMO and PPO concepts?
- What sort of "hold harmless" contracts are advisable?
- Do roles and relationship patterns need to be redefined for physicians who come to work for, or contract with, a tribe using managed care concepts?
- What various kinds of networking and contracting arrangements can be made?

- What procedures should be established to regulate referrals for special services (e.g. diabetes)?
- Could IHS headquarters and GAO provide training to area contracting units and project officers in skills necessary for, and unique to, medical/health services contracting?
- Could IHS revise the requirement that providers who do not have the Medicare DRG rate must have headquarters approval before they are contracted by a local unit?
- Can IHS adjust its current method for determining staffing levels in order to increase service unit staff positions and resources for the increasing work loads which come with more comprehensive health care planning?

Financing Health Care.

- What financial incentives are there for a tribe's choosing to implement managed health care concepts at the local level?
- Will tribes that increase care efficiency through managing their health care dollars suffer a decrease in their base funding as a result?
- Will IHS be able to fund the administrative staff, the additional space and the equipment necessary to implement managed health care concepts?
- Besides increasing the efficiency — through managed health care concepts — of present health care programs, what other steps can be taken to close the gap between health resources needed and available financial resources?

Recordkeeping and information Systems.

- What constitutes a patient day for IHS?

- How can the CHS management information system capture clinical data and financial data?.
- How can the bill paying mechanisms of local health service units capture information to indicate where and what alternate payment sources (Medicaid, insurance, family copayment, etc.) may exist for any particular patient?
- How can the CHS Management Information System be made more useful to primary users?
- Can an integration and evaluative system be designed for the CHS/MIS?
- Can the current CHS/MIS computer program be modified to provide financial accounting data and diagnostic information?
- Can a "space for comments" be included in the current CHS/MIS to allow easy tracing of what is happening with individual purchase orders?
- Can the current CHS/MIS be tied in with other modules?
- How can the CHS/MIS be integrated with the PCIS system for data analysis in order to manage patient care?
- Can the IHS annual data set be made available for local input at the beginning of the fiscal year?
- Because present data systems — both on the tribal and federal level — are incomplete, how can efficient managed health care programs be instituted at this time?

The Indian Health Service thanks workshop participants for their efforts in formulating and expressing the above questions. We will make an effort to respond to the ideas and issues presented.

Ramona Ornelas
Chief, Policy Analysis Branch
Office of Planning, Evaluation and Legislation IHS Headquarters

APPENDICES

APPENDIX A
INDIAN HEALTH SERVICE
MEDICAL PRIORITIES

A. EMERGENT/ACUTELY URGENT

This involves emphasis on geographic access to basic emergency services, stabilization of patients and appropriate referral patterns. It does not necessarily include the provision of or payment for highly sophisticated treatment once stabilization has occurred. A reasonable guide is: The condition presents: (1) an immediate threat to life, limb, or the senses, (2) a sufficiently unstable (immediate) potential course, (3) uncertain but grave (immediate) probabilities, (4) clear deterioration of patient's immediate condition, such that a reasonable average physician would not deiay (immediate) intervention.

B. PREVENTIVE SERVICES

Proven effective preventive services might be appropriately divided into primary, i.e., avoidance of the occurrence of the disease, and secondary, i.e., mitigation of its consequences. Ambulatory services of an interventive (secondary preventive) nature are included in this category if such services maintain health through preventing further long term morbidity. These services are to be distinguished, to the extent possible, from emergency care, sophisticated diagnostic procedures, treatment of acute conditions and care primarily intended for symptomatic relief and/or chronic maintenance or support.

Specific examples are: periodic health examinations of infants, children and adults; ambulatory interventional (secondary preventive) care; hypertension screening, diagnosis, and control; diabetes maintenance: pregnancy and infant care; family planning services; immunizations; sexually transmissible diseases services; tuberculosis control, screening, prophylaxis, and treatment of active cases; fluoridation of community water supplies; provision of routine pa;, smears ; provision of adequate mechanisms for water purification and disposal of solid waste; etc.

C. ACUTE AND CHRONIC PRIMARY AND SECONDARY CARE

This involves basic primary care, including the treatment of prevalent illnesses that have significant impact *on* morbidity: primary and selected secondary hospital care and selected sophisticated ambulatory services. Provision of services within this category should have a significant impact on morbidity and mortality, especially in areas such as pediatrics and obstetrics/gynecology.

Geographic access and other factors vary to the extent that it is impractical to specifically define all these services, and individual decisions should be left to the service unit and Area. Conditions not falling into categories A and B are to be reviewed by a "pre-authorization review process" at the service unit with input from the physician.

Specific examples are: access to obstetricians for complicated -maternal-perinatal conditions; surgical expertise to manage prevalent surgical entities, such as cholelithiasis; and internal medicine expertise to manage complicated adult illness: etc.

D. ACUTE AND CHRONIC TERTIARY CARE

This involves services that are not primarily preventive in nature, require sophisticated specialists and equipment/procedures which are not usually available in most small community hospitals, require a large amount of support capability, have a low cost/benefit ratio, are not immediately essential for initial hospital diagnosis or therapy in emergency situations, are elective and have less impact on mortality than on morbidity.

Specific examples are: coronary care, hemodialysis, neurosurgery, neonatal intensive care, restorative orthopedic procedures for chronic conditions, coronary bypass and valvular surgery, skilled nursing home care, periodontia, and provision of eye glasses, etc. (See Appendix 11 for other examples)

Controversial types of therapy will have a rigorous review (possibly including a second opinion process established by the Area Chief Medical Officer) to review such procedures as hysterectomies, disk surgery, T&A's, porta-caval shunts, obesity surgery, coronary artery by pass, etc. The decision is to be based upon such factors as: urgency, potential benefit/success to be expected, potential improvement in quality of life, funds available.

The availability of the Catastrophic Fund now allows IHS to fund some of the high-cost tertiary care which falls within overall medical priorities.

6. EXPERIMENTAL/NOT MEDICALLY NECESSARY

IHS will use the HCFA experimental procedure guidelines. This category also includes cosmetic procedures and those for which there is no proven medical efficacy. This category is not funded. See Appendix III for examples.

APPENDIX B

MEDICAL RECORD DOCUMENTATION OUTLINE

FOR REVIEW OR DOCUMENTATION PURPOSES

Recording these items, when appropriate, will improve the reviewer's understanding of the case, and, In borderline cases, save work.

On Admission, document or review for:

1. In the admission history,
   - Reason for admitting now versus outpatient observation or home care, including geographic and psychoscial factors.
   - Discussion of how outpatient therapy failed.
   - Reasons why problems were not resolved during previous recant admissions for the same diagnosis.
2. In the physicial,
   - Vital *signs.*
   - Assessment of distress, acuteness and severity of illness.
   - Description of patient's frailty, dependency or dementia.
3. Describe in general terms the plan for this admission, discussing reasons for any limited treatement plan.

In Progress Notes, document *or review for:*

1. Account for any expected laboratory and xray finding and untoward wants or contradictory allied health observations.
2. Explain thinking behind major changes in diagnostic efforts and therapy.

At Discharge, document or review for:

1. Primary diagnosis that explains admission and other diagnoses that required action, giving reasoning.
2. Abnormal lab, xray and nursing observations.
3. Note tests not reported at time of summary.
4. In the disposition section, document:
   - Support and caregiver arrangements.
   - Level of functioning.
   - Special problems: AMA discharge, poor cooperation, unstable condition.
   - Details of diet, medication, activity and education efforts.
   - Follow-up visit plan.

APPEN D IX C

QA/UM SCREENING ABSTRACT

:_____ PLAN_____ HOSP_____ ADMIT DATE_____ D/C DATE_____

ADDRESS:_____ GROUP_____ CONTACT_____ LOS_____

_____ PHONE #:_____ D/C PLAN_____

DOB_____ AGE_____ SEX_____ ACUTE DAYS_____ NON ACUTE DAYS_____ INTERVENTION_____

MHP #_____ ADMIT FROM:_____ COB___ SENS CASE___ OUTCOME_____

a m : . _____ MR#_____ H&P_/ / - ADMIT SUMMARY__/__/__ DISC SUMMARY__/__/__

ADMITTING DIAGNOSIS:_____ DISCHARGE PRINCIPAL DX:_____ DISCHARGE SECONDARY DX:_____

DATE	OPERATIVE/INVASIVE PROCEDURE	SURGEON	COMMENTS

ATTENDING MD_____ #_____ PRIMARY MD_____ #_____

CONSULTING MD_____ #_____ #_____

ADMISSION DATA/CLINICAL FINDINGS (INCLUDE LAB, XRAY, TREATMENT, MENTAL STATUS, MED., ETC.)_____

PREVIOUS HOSPITALIZATION DATE:_____ DATE:_____ DATE:_____

AMBULATORY CUE HISTORY DATE:_____ DATE:_____ REVIEWERS NAME:_____

DATE_____ AEP_____ REFER____ MSC_____ PR_____ APPROVE Y___ N___

INITIALS

DATE_____ AEP_____ REFER____ MSC_____ PR_____ APPROVE Y___ N___

INITIALS

DATE_____ AEP_____ REFER____ MSC_____ PR_____ APPROVE Y___ N___

INITIALS

SOCIAL INFORMATION:_____

SNF ____
HC ____
DME ____
TRANSPORTATION ____
NOTES MAINTENANCE ____

DATE_____ $_____
DATE_____ $_____
DATE_____ $_____
DATE_____ $_____

ABSTRACT

QA Screening Abstract Page 2 ... Number # ____________
12/..
Reviewers Name: ____________

DATE	ELEMENT
	1. ADMISSION FOR ADVERSE RESULTS OF OUTPATIENT/AMBULATORY MANAGEMENT
	2. READMISSION FOR COMPLICATIONS, INCOMPLETE MANAGEMENT ON PREVIOUS HOSPITALIZATION WITHIN 30 DAYS
	3. UNPLANNED REMOVAL, INJURY OR RPR OF ORGAN/STRUCTURE A. SURGERY C. VAGINAL DELIVERY B. INVASIVE PROCEDURED D. OTHER
	4. UNPLANNED RETURN TO OPERATING/DELIVERY ROOM, SPECIAL PROCEDURES ROOM ON THIS ADMISSION
	5. CARDIAC/RESPIRATORY ARREST/LOW APGAR SCORE
	6. TRANSFER FROM GENERAL CARE TO SPECIAL CARE UNIT A. COMPLICATION B. MANAGEMENT PROBLEM
	7. HOSPITAL-INCURRED PATIENT INCIDENT A. FALLS/ACCIDENTS D. EQUIPMENT PROBLEM B. IV PROBLEMS E. OTHER INCIDENTS C. SKIN PROBLEMS F. NURSING PROCEDURAL ERRORS

DATE	ELEMENT
	8. NEURO DEFICIT NOT PRESENT ON ADMISSION
	9. TRANSFER TO ANOTHER ACUTE CARE FACILITY A. FINANCIAL C. COMPLICATION B. MGT NOT AVAILABLE D. PATIENT OPTION
	10. DEATH
	11. UTILIZATION VARIATIONS A. UNJUSTIFIED ADMIT E. RESOURCE UTILIZING B. CONCURRENT GUIDE NOT MET C. PREOP SURGERY DAY F. SPECIAL CARE UNIT D. TERM OF BENEFITS G. ALTERNATE CARE N/A
	12. DEPARTMENTAL OR OTHER PROBLEMS
	13. PATIENT/FAMILY DISSATISFACTION
	14. INAPPROPRIATE DISCHARGE PLANNING A. PRO GUIDE NOT MET B. REFERRAL/RESPONSE C. FAMILY NON COMPLIANCE
	15. RECORD DOCUMENTATION

ATTRIBUTION
HOSPITAL MED/SURG
OTHER DEPT: ________
HOME CARE
EMERGENCY DEPT
OUT PT/AMBULATORY
SNF
PRACTIONER
OTHER: ____________

QA USE ONLY

DO NOT COPY FOR DISTRIBUTION

CRITERION NUMBER	DATE/TIME OF VARIATION	MSC'S COMMENT (IDENTIFY QA ISSUE, DATE INCIDENT OCCURRED, DEPT ISSUE IS ATTRIBUTED TO, CURRENT PATIENT STATUS)	SECONDARY MD REVIEW DATE OF REVIEW ____________
			FOLLOW UP:
			TREND BY: CRITERION PRACTITIONER

HOSPITAL RIS-K EXPOSURE BY TYPE OF CONTRACT

	Contract				No Contract	
	Prepaid		Fee-for-Service		Traditional Insurance	
Risk Exposure	Percent of Premium	Capitation	Per Service	Per Diem	Discounted Charges	Charges
Price	●	●	●	●	●	
Intensity	●	●	●	●		
Severity	●	●	●			
Frequency	●	●				
Actuarial/ Marketing	●					

Definitions:

Discounted Charges - Discount qff of routine charges

Per Diem - Flat daily rate which covers routine and ancillary services. Hospitals may receive one per diem, or different per diems for intensive care, obstetrical and medical or surgical cases.

Per Case - Prices vary by diagnosis and are a fixed amount per case

Capitation - A single per member per month rate for all inpatient care provided to HMO enrollees

Percent Premium - Plan pays a predetermined percentage of premiums to the hospital for coverage of specified services to the enrolled population.

PHYSICIAN & HOSPITAL UTILIZATION INCENTIVES BY TYPE OF REIMBURSEMENT

Type of Reimbursement	Hospital Incentives	Physician Incentives	UR Incentives for Hospitals	Utilization Concerns of Payors
Cost-Based, With or Without Discounts	1. Increase Admissions 2. Increase LOS 3. Increase Ancillary Service Use	1. Retain Status Quo	1. Profile Analysis by Diagnosis, Physician	1 Admission Review 2. Continued Stay Review 3 Ancillary Service's Review 4 Discharge Planning 5. Quality of Care
Prospective Per Case	1. Increase Admissions 2. Reduce LOS 3. Reduce Ancillary Service Use 4. Increase Volume of Moneymaking DRGs	1. Retain Status Quo	1. Continued Stay Review 2 Discharge Planning 3. Ancillary Service's Review 4. DRG Profile Analysis	1 Admissions Review 2. Quality of Care 3 Manipulation of Diagnoses 4. Access to Care
Prospective Per Diem	1. Increase Admissions 2. Increase LOS 3. Reduce Ancillary Service Use 4. Increase Volume of Less Ill Patients	1. Retain Status Quo	1. Ancillary Service's Review 2 Profile Analysis by Diagnosis, Physician	1 Admission Review 2 Continued Stay Review 3 Quality of Care 4 Access to Care
Prospective Capitation	1. Reduce Admissions 2. Reduce LOS 3. Reduce Ancillary Service 4. Increase Volume of Less Ill Patients	1. Reduce Admissions 2 Reduce LOS 3. Reduce Ancillary Service	1 Pre-Admission Certification 2. Continued Stay Review 3 Discharge Planning 4 Ancillary Service's Review 5. Profile Analysis by Diagnosis, Physician	1 Quality of Care 2 Access to Care

Source "Utilization Review. Past, Future," Interstudy, December, 1988

KIND OF DELIVERY SYSTEM

DESCRIPTION	IPA	NETWORK	GROUP	STAFF
LOCATION OF MD	OWN OFFICE CAN BE SOLO	SMALL PRACTICES SMALL MULTI-SPECIALTY GROUPS	PRACTICE IN ONE LOCATION MAY/MAY NOT BE OWNED BY PLAN	ONE LOCATION OWNED BY PLAN OR INVESTORS
FORMATION	FORMED FOR CONTRACTING SLOW PROCESS FOR FIRST HMO	BANDED TOGETHER BY HMO	OFTEN FORMED FOR HMO	HIRED BY HMO
CONTRACT WITH MULTIPLE HMOs?	CONTRACT WITH MANY HMOs	CONTRACT WITH MANY HMOs	EXCLUSIVE	NO
PAYMENT	CAPITATION TO IPA MDs OR FEE FOR SERVICE	CAPITATION TO IPA IND. GROUPS MDs OR FEE FOR SERVICE GROUPS MDs	CAPITATION TO GROUP SALARY TO MD	SALARY
INCENTIVES	MOSTLY FINANCIAL	MOSTLY FINANCIAL	MOSTLY PEER	MOSTLY PEER
USE OF MD EXTENDERS	LITTLE	LITTLE	SOME	MOST
OWN HOSPITALS	NO	NO	PLAN SOMETIMES	PLAN SOMETIMES

APPENDIX E

CONTRACT EVALUATION CHECKLIST

I. Definitions

II. Terms, Termination, Renewal

III. Provider Responsibilities & Services

IV. Health Plan Responsibilities & Services

V. Compensation and Billing

VI. Utilization Review

VII. Records

VIII. Marketing

Ix. Dispute Resolution

x. Other

CONTRACT ISSUES

I. Definitions

- emergency and urgent care
- medically necessary
- participating provider
- covered member

II. Term, Renewal Arrangements, and Renegotiation of Contract

A. Term

- typically annual

B. Automatic renewal provision

C. Renegotiation of contract terms

- effective date of renegotiated terms:

30 days, 60 days, 90 days, first day of succeeding contract term

D. Termination of contract

- if, on termination of contract, any patients remain in the hospital/clinic, is the hospital/clinic obligated to serve those patients?

- how shall the hospital/clinic be reimbursed for those services?

- can there be termination without cause?

- are there restrictions on entering into new contracts covenants not to compete?

- use of HMO trade secrets

III. Provider Responsibilities and Services

A. Contract should clearly specify the services that are to be provided

- Issue: Should services be limited to the customary services provided by the hospital or physician?

B. Provision for capacity constraints

C. Anticipated membership

D. For physician contracts, does the physician have right not to accept a patient, or to break a provider relationship? Does the member have the right to break a provider relationship?

E. For hospital contracts, is there a duty to accept any participating physician to medical staff? Is the hospital/clinic guarantor of physician behavior?

F. Transportation of patients from one facility to another

G. Hospital emergency room services

H. Timely review of application for staff privileges

IV. Health Plan Responsibilities and Services

A. Contract should clearly specify who will pay hospital

B- Regular update of eligibility information to be provided to Provider

C. Marketing, Advertising and Publicity

D. Provide list of other participating Providers

E. Need definition of process to conclusively verify eligibility

V. Compensation and Billing

A. Billing for noncovered services

B. Basis of payment

- Hospitals: per diem or multiple per diems
  capitation
  charges
  % of charges
  etc.

- Physicians: URC
  % of billed charges
  RVS times conversion factor
  workmen's compensation schedule times conversion factor

C. Withhold arrangements

D. Upfront costs of participation

E. Statement on how copayments and deductibles will be handles, collected

F. Retroactive Terminations: Provider liability

G. Coordination of Benefits

H. Timing - Turnaround by hospitals
  Turnaround by plan

I. Physician referral procedures

J. Quality of care requirements

- clean facilities
- JCHA accreditation
- efficient admitting/discharge system
- maintain medical records
- failure to correct deficiency shall be a breach of Agreement

K. Access to records for utilization review

L. Preadmission testing requirements

M. Investigation and resolution of complaints

N. Use of hospital/facility name. Approval of advertising materials

O. Procedures for determining member eligibility

- who pays for care delivered to ineligibles'?

VI. Utilization -Review

A. Who performs, who pays?

B. Components

C. Appeals process

D. No retroactive denial if services approved in advance

VII. Records

A. Need statement assuring confidentiality of records

B. Providers should limit the Company's access to the medical records to reasonable times or hours

C. Who pays for the costs of duplicating the records for the Company's use?

VIII. Marketing

A. Providers should reserve the right to review and approve all marketing and advertising materials using hospital or physician name

IX. Dispute Resolution

A. Contract should include an arbitration clause and should define the composition of the hearing panel

X. Other

A. “Force majeure” clause:

- hospital/clinic not responsible for delivering its contracted services in case of catastrophe affecting hospital/clinic operations, such as labor disputes, war, fire, act of God

CONTRACT REVIEW FORM

CONTRACTED PARTY _____

CONTACT PERSON _____
TELEPHONE _____
ADDRESS' _____
_____

EFFECTIVE DATE _____

TERMINATION DATE _____

RENEWAL TERMS _____

TERMINATION NOTICE _____

RATE RENEGOTIATION PROCESS _____
_____

ASSIGNABLE _____

BILL SUBMISSION

TIMING _____

SPECIAL FORMS/ ATTACHMENTS REQUIRED _____

REIMBURSEMENT

TIMING _____

PENALTY FOR LATE PAYMENT _____

APPEAL PROCESS _____
_____

LIABILITY COVERAGE _____
_____

PREADMISSION REQUIREMENTS

ELIGIBILITY/AUTHORIZATION PROCESS (NON-ER)

PENALTY FOR NON-COMPLIANCE

(EMERGENCY AUTHORIZATION PROCESS)

PENALTY FOR NON-COMPLIANCE

ID CARDS

PHYSJCIAN VERIFICATION PROCESS

UTILIZATION REVIEW

EXTENSION PROCESS

UR/QA RESPONSIBILITIES

MEDICAL RECORD REQUESTS

TIMING _____

REIMBURSEMENT _____

_____

NOTABLE SERVICE EXCLUSIONS _____

_____

PAYMENT TERMS

INPATIENT

OUTPATIENT

COB _____

_____

OTHER CLAUSES AND/OR QUESTIONS:

CONTRACT MANUAL

1. Development
   - Process
   - Information
2. Communication
3. Maintenance

CONTRACT MANUAL

I. Development

Process:

- Identify who will use manual and for what purpose (i.e., Finance Manager to have reimbursement rates readily accessible).

- Determine (using above information) what information to be included in manual

  Allow key managed care related personnel to review list and comment. (Be sure to encourage key people to ask staff personnel what they need to know.)

- Consider Style of manual to be presented in a user friendly format.
  - easy to read
  - easy to understand

Information:

Examples of information to include in your Contract Manual (Exhibit 1)

II. Communication

- Disseminate the Contract Manual to key people
  - UR
  - ER
  - Admitting
  - Billing
  - Finance
  - Administration

- Tailor Contract Manual to the people who are going to use it

- Spend time educating everyone as to what the manual can tell you

  - opportunity for general managed care education

  - opportunity for better management of precextified Managed Care patients

III. Maintenance

- Identify for the Hospital and HMO/PPO the contact person for all updates

- Update all manuals as key information changes

- Meet regularly with Managed Care related Hospital personnel to update on important managed care information and feedback

Examples of What to Include

In Your Contract Manual

1. Copies of Managed Care Strategy Statement

2. Copies of all contracts (this would not be disseminated to all key personnel)

3. Copies of ID cards and phone numbers

4. Calendar of renewal dates

   - Termination Notice Requirements
   - Effective Dates

5. List of Contact People and Phones

6. List of all the individuals who receive this information (managed care has become so fragmented in the hospital--good to keep everyone aware of who is involved

7. Other/Miscellaneous--Area for general communications regarding contracts

8. Examples of a Worksheet identifying key contract information
   (Contract Review Form)

APPENDIX i

FACULTY LIST
INDIAN HEALTH SERVICE
"MANAGED HEALTH CARE STRATEGIES WORKSHOP"
Minneapolis, Minnesota
November S-8,1990

David Aquiiina
Independent Consultant
4817 Vinccent Avenue South
Minneapolis, MN 55409
(612) 922-5551

Kris Carlton
Medical Policy Director
Aetna Health Plans
7760 France Avenue South, **Ml303**
Mineapolis, MN 55435
(612) 897-2983

Jill Klingner, RN, PHN
Medical Services Coordinator
MedCenters Health Plan
5050 Excelsior Boulevard
Minneappolis, MN 55416
(612) 925-8535

Shelia Leatherman
Vice President
Research and Development
United Health Care
9900 Bren Road East
Minneapolis, MN 55440-8001
(612) 936-7373

Jan Malcolm
Vice President
Policy and Development
Croup Health
2829 University Avenue, SE
Minnneapolis, MN 55414
(612) 623-8464

Brian Osberg
Senior Vice President
Lifespan
800 East 28th Street
Minneapolis, MN 55407
(612) 863-5106

Ellen Pinkowski, RN, PI-IN
Manager, Concurrent Review
MedCenters Health Plan
5050 Excelsior Boulevard
Minneapolis, MN 55416
(612) 925-8952

Gloria Swanson
Director, Medical Services
MedCenters Health Plan
5050 Excelsior Boulevard
Minneapolis, MN 55416
(612) 925-8952

PARTICIPANT LIST

INDIAN HEALTH SERVICE
"MANAGED HEALTH CARE STRATEGIES WORKSHOP"
Minneapolis, Minnesota
November 5-8, 1990

Phillip L. Ambrose III
Program Manager
Contract Health Services
Yakima Nation
P.O. Box 151
Toppenish, WA 98945
(509) 865-5121, ext.381

Beverly A. Bouschor
Contract Health Services Administrator
Sault Stc. Marie Tribe of Chippewa Indians
2218 Skunk Road
Sault Ste. Marie, MI 49783
(906) 635-6070

David Campbell
Community Health Representative
Fort Peck Tribes
Poplar, MO 59255
(406) 768-5302

Erica W. Clary, RN
Vice President
TCI, Incorporated
3410 Garfield Street, NW
Washington, DC 20007
(202) 333-6350

Thomas C. Clary, PhD
President
TCI, Incorporated
3410 Garfield Street, NW
Washington, DC 20007
(202) 333-6350

Naomi Corbine
CHS Clerk
Lac Court Oreilles Community Health Center
Route 2, Box 2750
Hayward, WI 54843
(715) 634-4797

Patty Deragon
Contract Health Services
Red Cliff Tribe
P.O. Box 529
Bayfield, WI 54814
(715) 349-5768

Anita Dupuis
Director, Economic Development
Confederated Salish & Kootenai Tribe
P. 0. Box 278
Pablo, MT 59855
(406) 675-2700

Merlan 0. Ellis
Director, Contract Health Services
Tanana Chiefs Conference, Inc.
1638 Cowles Street
Fairbanks, AK 99701-5999
(907) 451-6682

Doris Emery
Health Director
St. Croix Tribe
P.O. Box 287
Hertel, WI 54845
(715) 349-5768

Tina Fox
Contract Health Services Assistant
Sault Ste. Marie Tribe
of Chippewa Indians
2218 Shunk Road
Sault Ste. Marie, MI 497883
(906) 635-6070

Dennis M. Funmaker
Assistant/Executive Health Director
Wisconsin Winnebago Tribal Health Department
P.O. Box 663
Tomah, WI 54660
(608) 372-5202

Lisa Giles
Medical Social Worker
Suquamish Tribe
P.O. Box 498
Suquamish, WA 98392
(206) 598-3311

Iris Gray
CHS Manager
S.E. Alaska Regional Health Corp.
222 Tongass Drive
Sitka, AK 99835
(907) 966-8316

Wade Henry
Chief, Division of Contract Health Care
Alaska Area Native Health Services
2.50 Gambell Street
Anchorage, AK 99501
(907) 257-1368

Linda Jones
Services Manager
Tulalip Board of Directors
6700 Totem Beach Road
Marysville, WA 98270
(206) 653-4585

Ardis Mayotte
Health Director
Bad River Tribe
P.O. Box 39
Odanah, WI 541.55
(715) 682-5852

Raya Menard
Contract Health Services Assistant
Sault Ste. Marie Tribe
of Chippewa Indians
Sault Ste. Marie, MI 49783
(906) 635-6070

Marie Moses
Acting Director
Contract Health Services
Portland Area Indian Health Service
1220 S.W. 3rd Avenue, Room 476
Portland, OR 97X4-2892
(505) 326-7277, or 326-2008

Janet Nelson
Contract Health Services
St. Croix Tribe
P.O. Box 287
Hertel, WI 54845
(715) 349-2198

Sharon Odegard
Contract Health Services
Upper Sioux Board of Trustees
Box 147
Granite Falls, MN 56241
(612) 564-2360

Ramona C. Omelas
Chief, Policy Analysis Branch
Indian Health Service
Parklawn Building, Room 6-40
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4700

Sarah Plotkin
Consultant/Actuary
TPF & C
1111 3rd Avenue, Suite 2185
Seattle, WA 98101
(206) 343-6035

Kieth A. Radcliffe, MPH
Health Director
Wampanoag Tribe of Gay Head
RFD 137 State Road
Gay Head, MA 02535
(508) 645-3515

Mary Ramsey
Director
Indian Health Service
Contract Health Services Administration
New Mexico Blue Goss Blue Shield
12800 Indian School Road N.E.
Albuquerque, NM 87112
(505) 291-3590

Ethei Schauske
Contract Health Services
Stockbridge-Munsee Comprehensive
Health Center
P.O. Box 86
Bowler, WI 54814
(715) 793-4144

Alan E. Shelton, MD
Puyallup Tribal Health Authority
2209 East 32nd Street
Tacoma, WA 98404
(206) 593-0238

Joan Slack
Health Director
Red Cliff Tribe
P.O. Box 529
Bayfield, WI 54814
(715) 779-5801

Lynn Spry
CHR-CHS Clerk
P.O. Box 428
Grand Portage, MN 55605
(218) 475-2302

Julie M. Vassar
Contract Health Services Specialist
Inter-Tribal Council of Michigan, Inc.
312 Water Tower Drive
Kincheloe, MI 49788
(906) 495-2289

Darlene Walitalo
Contract Health Services Clerk
Hannahville Indian Community
N14925 Hannahville B-l Road
Wilson, MI 49896-9728
(906) 466-2651

Wanda Webster
Contract Health Services
Oneida Health Center
P.O. Box 365
Oneida, WI 54155
(414) 869-2711

Marcia Whelan
Menominee Tribal Clinic
Box 235
Keshena, WI 54135
(715) 799-3341

Earl Jones, Jr.
Sioux, Ft. Peck
Asst. Director, T.H.
Coordinator, C.H.R.
Box 264
Popular, Montana
(406) 768-3389

Bonnie J. Gerow
CHS/AHR Manager
ANMC
255 Gambell
Anchorage, AK
(907) 257-1517

Dennis M. Funmaker
Asst/Exec Health Director
Wisconsin Winnebago
P.O. Box 663
Tomah, WI 54660
(608) 372-5202

Chuck Walt
Asst Director
Fond du Lac
927 Trettei Lane
Cloquet, MN 55720
(218) 879-1227